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ABSTRACT

The manual for rehabilitation counselors of multiply disabled deaf persons has been developed from a workshop in which vocational counselors discussed stages of the rehabilitation process. Guidelines for the procedures of identification, differential diagnosis, vocational evaluation, placement, and follow-up are given for deaf persons also handicapped by mental retardation, emotional disturbance, learning disabilities, or other severe handicaps. A brief description of the rehabilitation process is directed to readers not familiar with the field. Guidelines include such suggestions as using the TOWER system for evaluating work skills, particularly of mentally retarded persons, and being alert for emotional disturbance when school and other records so indicate or when the client's verbal behavior betrays inconsistencies. Also provided are such aids as a flow chart for the identification, assessment, and referral of deaf children having difficulty in school, and a checklist for the identification of the atypical deaf adult. Appendixes include a listing of service centers for deaf people, a bibliography on deafness and other disabilities, a listing of psychological tests, and directory of workshop participants. (GW)

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MULTIPLY DISABLED DEAF PERSONS:

A Manual for Rehabilitation Counselors

A Report of A Workshop On Comprehensive Vocational Rehabilitation Services for Multiply Disabled Deaf Persons

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MULTIPLY DISABLED DEAF PERSONS:

A Manual for Rehabilitation Counselors
Developed at a
Workshop in New Orleans, Louisiana
March 31 through April 3, 1968

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U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
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Preface

The Rehabilitation Services Administration is pleased to make available this reissue of *Multiply Disabled Deaf Persons; A Manual for Rehabilitation Counselors.* It has been extremely helpful in focusing needed attention on the problems of deaf people with additional disabilities such as mental retardation, emotional disturbance, learning disabilities, vision impairment, cerebral palsy, and other disorders.

While underservice to multiply disabled deaf people continues to be a persistent and pervasive problem, the future appears to be bright with plans underway for the establishment and operation of rehabilitation centers where deaf persons with complex needs will be able at long last to obtain the special services they require.

It should be a great satisfaction to the individuals who participated at the workshop which produced this document to know that they had an important role in generating action that promises to do so much for multiply disabled deaf people.

Edward Newman

Commissioner
Rehabilitation Services
Administration

December 1972

Foreword

Another important milestone in service to deaf people has been realized in the publication of this document, the report of a workshop to develop guidelines in the vocational rehabilitation of multiply disabled deaf persons.

The handbook is a tribute to those persons who have long been concerned with the plight of deaf people who are unserved or underserved due to complex physical, emotional or mental conditions that make service to them difficult.

The encouraging pioneer work done at special programs for multiply disabled deaf people has shown clearly that appropriate practices and inspired service are the keys to their rehabilitation fulfillment.

It is hoped that this manual which describes the deeper services and counseling techniques that are helpful to multiply disabled deaf persons will be an inspiration and a challenge to vocational rehabilitation counselors and others who work with them.

It was a particularly meaningful experience for the Rehabilitation Services Administration to share in the production of this document which promises to open the door for more and better services to multiply disabled deaf people. To the sponsoring institution, DePaul University, the planning committee, and to all of the other workshop participants, I extend my special appreciation.

JOSEPH HUNT
Commissioner

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Introduction

For the past dozen years the problem of multiple disabilities and the concomitant added handicaps has loomed menacingly upon the horizons of education and rehabilitation. As medical skills have saved more and more persons from death, more and more have had to face life with multiple disabilities. Since deafness, of itself, entails an intricate complex of handicaps, the problem has been particularly acute for workers with deaf people.

Concurrently there has been growth of professionalism among rehabilitation workers. As demands upon the service have grown, new disciplines have been involved. The rehabilitation worker has found a multitude of professional services available for his clients. His function of liaison and coordination has come to demand a truly interdisciplinary approach, and consequently a broad understanding of numerous complex professions. The general counselor, faced for the first time with the complexity of deafness compounded by secondary disabilities and with a spectrum of many professional services available, might be excused for feeling overwhelmed and in need of aid.

As a step toward providing such aid, a workshop to develop guidelines for the establishment of comprehensive vocational rehabilitation services for the multiply disabled deaf was held in New Orleans March 31 through April 3, 1968. The purposes of the workshop were:

> To develop guidelines and to report techniques for the establishment of comprehensive vocational rehabilitation services for the multiply disabled deaf in the areas of identification, evaluation, training, placement, and follow-up.
>
> To provide vocational rehabilitation counselors and supporting personnel with techniques and knowledge usable in aiding the adjustment needs of the multiply disabled deaf.
>
> To acquaint such workers with principles, practices, and procedures in the use of the interdisciplinary approach to case services.
>
> To develop practical department of vocational rehabilitation/school and other sources of referral relationships in the vocational rehabilitation process.

The discussants were divided into four groups according to the

secondary disabilities which might be expected with deafness: mental retardation, emotional disturbance, learning disabilities, and other severe handicaps. Each group included vocational rehabilitation workers and experts in the particular field and they remained together throughout the six discussion sessions. The discussions covered (1) identification, (2) evaluation—differential diagnosis, (3) evaluation—vocational, (4) training, (5) placement, and (6) follow-up.

An important aim of the workshop was to provide a pragmatic working manual for day-to-day use by rehabilitation counselors and supportive personnel. Hence this report is presented in the format of a manual. The provacative papers which led off the discussions are omitted, recommendations and resolutions have been placed in the appendix, generalities on rehabilitation of deaf people are gathered in a general chapter and a chapter is devoted to each of the disability groups mentioned above.

CHAPTER 1

General Principles and Practices in Rehabilitation of Deaf Clients

There are certain general practices applicable to rehabilitation of deaf clients which are useful in serving multiply disabled deaf persons, whatever the secondary disability may be. Such general activities on behalf of deaf (rather than multiply disabled) persons have been gathered in this chapter. The first section is a brief description of the rehabilitation process; it is included for those readers not familiar with the field. The remaining sections deal with the procedures involved: identification, evaluation, training, placement, and follow-up.

THE VOCATIONAL REHABILITATION PROCESS*

By LARRY G. STEWART
Director, Project with Low-Achieving Deaf
Hot Springs Rehabilitation Center

The State-Federal program of vocational rehabilitation has as its objective the restoration of disabled people to fullest possible productive living. The work of this program is manifest in the vocational rehabilitation process, which involves the provision of a variety of services designed to bring physically, mentally, and emotionally disabled individuals to their best functioning level in terms of job performance, personal adjustment, and social productivity. The process is essentially one of change, and is mediated by the vocational rehabilitation counselor who coordinates, in a meaningful way, the community resources which are available for the rehabilitation of disabled persons.

* Mr. Stewart presented these ideas briefly at the workshop and generously agreed to expand upon them for this manual.

The vocational rehabilitation process is dynamic and client-centered. The needs of the disabled clients are the determinants guiding the selection of specific community services which are brought to bear on his problems. There are well-defined stages in the rehabiiitation process, including casefinding and referral, preliminary case study, the case study, the vocational rehabilitation diagnosis, planning goals and services, and provision of services. These stages are presented schematically in the diagram on the opposite page.

Casefinding and Referral

Casefinding and referral involve activities designed to acquaint the disabled with the services available through vocational rehabilitation and to stimulate them to apply for its program of services. Community agencies, interested persons, and disabled people themselves play an active role in the casefinding and referral process.

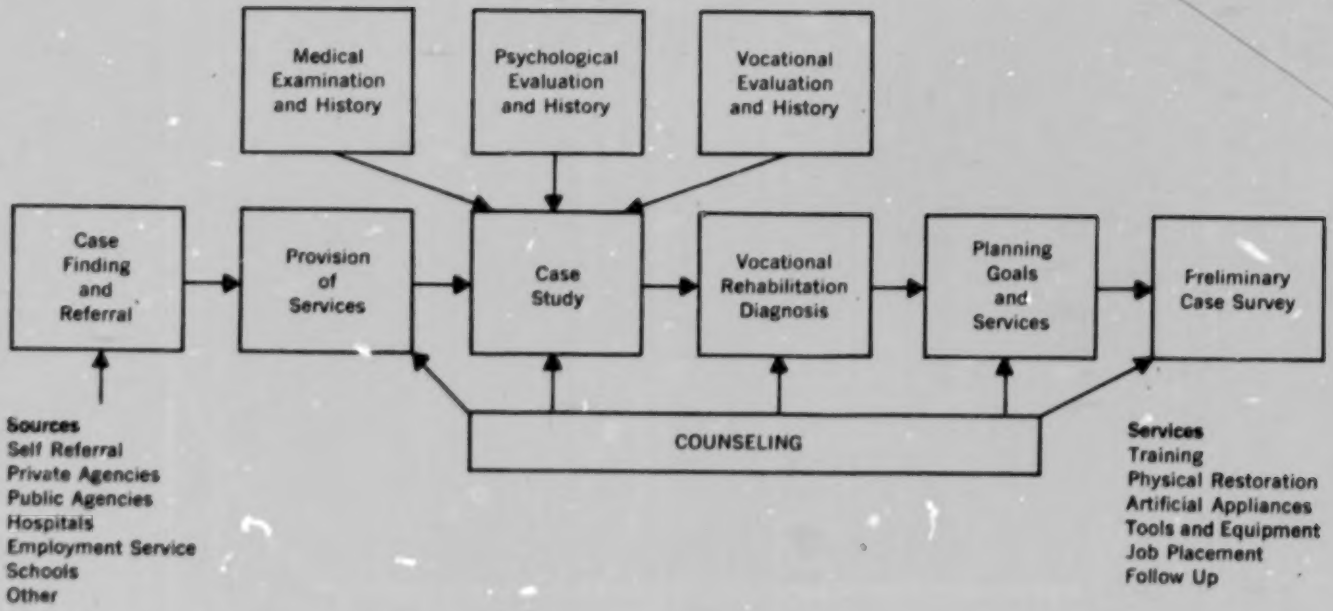
Preliminary Case Study

Once the disabled person has been referred to the vocational rehabilitation agency the actual casework process begins. The preliminary case survey is concerned with the collection of information which will assist the counselor in reaching a decision on whether the applicant will be accepted or rejected for further consideration for services. Certain basic information on the client is obtained from the referral source and from other sources which may have important data on the client. During the initial interview between the counselor and the client, the client is encouraged to describe his problems as well as his interest in and understanding of vocational rehabilitation. The counselor explains the vocational rehabilitation program and its requirements and attempts to assess the motivation of the client. He also obtains more detailed information on the client which will enable the counselor to decide whether the case warrants further consideration or rejection and referral to another agency.

The Case Study

The purpose of the case study is to assemble useful background and current evaluation information on the client which will enable the counselor to answer these questions:

1. Does the client have a disability?
2. Is the disability a substantial handicap to employment?



THE VOCATIONAL REHABILITATION PROCESS

3. Is there a reasonable expectation that through vocational rehabilitation services the client can be successfully rehabilitated?

To answer these questions the counselor will require the following information: current status of health and physical history, intellectual potential and educational history, vocational experiences, home and family relationships, and personal and social adjustment patterns. This information is obtained from general medical doctors, medical specialists, psychologists, vocational evaluation centers, schools the client has attended, previous employers, the client's family, and the client himself. All of these sources are contacted only when permitted by the client. The counselor uses judgment based upon training and experience to determine the types of information needed, and consults with professionals from medicine and other areas with respect to the types and depth of information needed. In certain cases it may be necessary for the client to undergo extended vocational evaluation for a period of time in a rehabilitation center before the counselor will have all of the information he needs to complete his case study. Once the needed information has been assembled, the counselor is ready to reach a vocational rehabilitation diagnosis.

The Vocational Rehabilitation Diagnosis

The counselor uses the information obtained during the case study period to determine the client's eligibility for services and to identify the needs of the client which must be fulfilled before he can function at his best level. Once eligibility has been determined and needs have been agreed upon by the client and the counselor, they can move into the planning stage.

Planning Goals and Services

The counselor and client explore possibilities in employment, agree on an employment objective, formulate a rehabilitation plan which will enable the client to achieve the objective, and make preparations for initiating the plan. The client is helped by the counselor to understand and carry out his responsibilities in the rehabilitation program, and the counselor and client make the necessary arrangements with community resources to meet the client's needs.

Provision of Services

The counselor and client work together to select the best facilities available to meet the client's rehabilitation needs. The

counselor draws up agreements with the community resources providing services for the client and arranges for financial reimbursement for these facilities. Where training is provided, the counselor arranges for periodic training reports and discusses any problems which come up with the client and the training agency. With other types of services such as physical restoration, the counselor maintains close contact with the agencies concerned to see that the services agreed upon are provided. Once all agreed-upon rehabilitation services have been provided and the client is ready for employment, the counselor and client develop a procedure for job placement. Other agencies such as State employment agencies and governmental agencies are contacted for assistance where indicated. The client is encouraged to take the initiative in finding employment commensurate with his abilities, interests, and personal characteristics, but the counselor plays a major role in this area whenever indicated by the circumstances of the individual client. During the first stages of employment the counselor maintains contact with the client and his employer to ascertain the progress of the client and to offer counseling when indicated. When it has been ascertained, after a reasonable period of time, that the client is suitably employed and the employer is satisfied with his work, services are terminated and the case closed.

This is the essence of the vocational rehabilitation process. The stages in the process are well-defined by their nature and are basically similar in all vocational rehabilitation agencies, although agency requirements and counselor competence may vary to some extent. Throughout the process, however, counseling provides the continuity which ties the stages together. Most disabled clients require counseling to help them to obtain maximum benefit from rehabilitation services. Thus counseling pervades the entire process, starting with the initial interview and continuing until case closure. The emphasis in counseling is on the client and his perceptions and feelings toward himself and his problems. The ultimate objective is, of course, vocational adjustment, but in the process good social and personal adjustment are vital.

* * * * * * * * * * * * * *

The remainder of this chapter is devoted to expansion upon the general vocational rehabilitation process as applicable to deaf persons. Subdivisions of the text are those employed at the workshop where this manual was developed; these subdivisions and their relationship to those developed by Mr. Stewart are:

Identification	Case finding and referral
Evaluation	Preliminary case study, case study, the vocational rehabilitation diagnosis, and planning goals and services

Training
Placement } .... Provision of services
Follow-Up

IDENTIFICATION

The recent rubella epidemic of 1963–65, with its implications for a high incidence of multiply handicapping conditions, underscores the present need for sophisticated identification procedures in rehabilitation efforts.

In the area of deafness, the counselor needing both general information and advice on specific problems might contact one of the following training programs for rehabilitation counselors working with the deaf:

College of Education, University of Tennessee, Knoxville, Tennessee 37916

Department of Special Education and Rehabilitation, School of Education, University of Pittsburgh, Pittsburgh, Pa. 15213

Division of Special Education, Department of Education and Psychology, Oregon College of Education, Monmouth, Ore. 97361

School of Education, College of Education, The University of Arizona, Tucson, Arizona 85721

School of Education, New York University, New York, N.Y. 10003

In going into a new community, the counselor who expects to work with the deaf might begin by sending out a questionnaire to as many deaf persons as can be contacted.* This survey will provide him with (1) a directory of deaf persons in the area, (2) a roster of industries where deaf persons are employed, for later contact, and (3) a roster of deaf resource persons who can, and are willing to, assist in many phases of the rehabilitation process. It should be emphasized that leaders in the deaf community are excellent resource persons for the local counselor, especially in his dealings with multiply disabled deaf clients. They can interpret or recommend interpreters for low-verbal clients who have difficulty in expressing their feelings and intentions. Perhaps the most effective way for a rehabilitation counselor to reach deaf people for identification and referral is for him to establish a reputation for good services to his clients. The community of deaf

* The annual directory issue of the *American Annals of the Deaf* is a useful source of information about local deaf leaders and organizations of and for deaf people.

persons has a highly developed system for disseminating information important to its members.

Members of the deaf community and individual friends or associates of the deaf client can aid in identifying secondary handicaps by providing reports of current behavior. Such reports can also be obtained from the family, hearing friends, interpreters, and current rehabilitation workers. Other sources of information which may disclose special problems are medical and school records, family relationships, work histories, and reports of psychologists, rehabilitation counselors, and social workers. All this information must be evaluated by the counselor in addition to his own observations during information-gathering interviews, and personality probings. Pertinent to the observation process are the client's life situation reactions, motor behavior, time and spatial relationships, and similar functioning.

Additional case-finding and diagnostic sources are given in the separate sections on each secondary disability.

EVALUATION

The evaluation procedures described in this manual are framed in terms of optimal working relationships among medical, paramedical, and vocational rehabilitation personnel in a team approach to the rehabilitation process. Some large urban areas in the nation are now providing these integrated and coordinated services. In many instances, however, this high level of service will not be available due to lack of local facilities or appropriate personnel or to inadequate communication and working relationships between existing agencies.

While the procedures set forth here are designed to meet the needs of the counselor working in an area where appropriate services are available, they might also serve as guidelines for the utilization of presently untapped local agencies and professional personnel. Finally, they may provide a basic plan of action to be adapted by the counselor working in an area with limited community resources.

Certain general principles are seen as basic to the entire evaluation process:

1. Evaluation is a *method* for testing the validity of the initial diagnosis and for developing plans to carry out the rehabilitation of the client.
2. Evaluation is a *continuous process* beginning with identification of client needs and ending only with the achievement of client independence.

3. Evaluation is a *comprehensive procedure* which requires the assistance of all professional and lay service resources available. It cannot be based on observations from fragmented services or be dependent on the skills of a single professional specialty. For example, medical evaluations should be conducted by a specialist for the medical area being evaluated, and audiological assessments by audiologists from speech and hearing centers. The team approach with case staffings is ideal; many rehabilitation facilities provide this approach plus an environment suited to structured behavior and skilled observation.
4. Evaluation is a *circular or cyclic approach* with constant repetition of each service stage on continuously higher levels. It is an active concern whatever the stage or level of the client's adjustment or the nature of any special services he may receive.
5. Evaluation is a *coordinated approach* for which the rehabilitation counselor assumes the major responsibility. Counselors are intended to assume over-all evaluation and management of their clients' progress in conjunction with whatever consultation may seem advisable.

With these principles in mind the counselor can explore a variety of resources for help in making the initial diagnosis and in providing a comprehensive evaluation of his deaf client.

Resources

The selection of evaluation procedures is based on data secured during early contacts with the client. Such data will normally include information on the person's innate capacities and limitations (intellectual, social, physical, and emotional), his educational background, vocational training, orientation to work, work history, and occupational patterns. It will also cover the client's future objectives and aspirations, his motivation for change and for services, and other data required for vocational evaluation and case study.

Much of this background information can be obtained by the counselor from appropriate sources. Etiological and medical information is available from relatives, friends, the school for the deaf or any other school attended, the family doctor or midwife, child welfare agencies, and hospitals. In rural areas the county health agencies and personnel can be used to obtain additional medical information; in city areas, hospital and university clinics, union hospitals and clinics, and specialists in various areas may be utilized.

The initial assessment of communication and academic skills may be based on information from the State school for the deaf,

speech and hearing clinics, hearing societies, societies and agencies serving other handicaps (blindness, crippling, and so forth), agencies and individuals concerned with social and religious activities, and leaders of the deaf community. The counselor's own observations will include how the family members communicate with the client. In city areas, trained interpreters are often available to assist with assessments.

In rural areas, the initial audiological screening may require primitive techniques such as finger snapping, clapping, use of noise makers; the county health nurse may provide this initial screening. Use of a portable audiometer or referral to a mobile clinic may be the most efficient arrangement. In the city, clients should be referred to an otologist and an audiologist. Hearing aid dealers are not qualified to make diagnostic evaluations. Specific information to be sought includes client utilization of amplification systems, hearing aid evaluations, and recommendations for communication training. The counselor should not predetermine the need for a hearing aid. A speech evaluation will be needed to determine the feasibility of speech or speech-retention training.

Skills for daily living may be assessed mainly through family information and counselor observations following the initial impression. The Vineland Test of Social Maturity may have some applicability to deaf clients. The counselor might usefully elicit information on ability to travel; degree of independence; budgeting ability; ability to follow directions, make purchases, and write checks; sense of responsibility; and leisure time activities.

The above information may be used by the counselor himself or may be passed on to any facility from which a comprehensive evaluation is desired. As has already been stated, the team approach to a comprehensive evaluation is preferable. Local facilities using this approach may be capable of handling deaf persons. If local facilities are not feasible or not available, the counselor may wish to set up a committee from the community to assist him in rehabilitation planning for his deaf clients. Such a committee might include speech therapists, audiologists, interpreters, teachers of the deaf from local or state schools, physicians, and other professional personnel. Evaluations by this group could serve as a basis for decisions made in conjunction with the client and the client's parents as to what services might most usefully be extended.

Alternately, the counselor might develop his own long-range program of acquiring evaluative services at the local level. He might use schools for the deaf, both private and public, as a starting point and investigate State regulations regarding the purchase of their services by the division of vocational rehabilitation.

In certain States this is not permissible; the counselor with no other resources might wish to instigate administrative interest in legislation to alter the situation.

Specialists from local hospitals, from the State department of education, from mental commissions or boards, and from other such bodies might be available for consultation. In sparsely populated areas it might be necessary that State lines be crossed in order to obtain services of an appropriate specialist. Regional programs could also be investigated. Specialists who have been hired with funds from Titles I, III, and VI of the Elementary and Secondary Education Act* by the local and State school systems as well as by special schools and institutions are other possible resource persons available to local counselors.

If, as will frequently be the case, particularly with the multiply disabled deaf client, the problems presented seem beyond the capacities of the counselor and/or local facilities, an appropriate resource will need to be found. Whenever feasible, the special rehabilitation centers serving this type of clientele in various parts of the country should be utilized.† There is an urgent need for the establishment of additional centers of this kind; however, it is hardly feasible to set them up in every State, regardless of size of population. The counselor who sees no more than 50–75 deaf clients per year would be advised to refer appropriate cases to these outside resources and carry the cost of transportation and maintenance for the sake of a more comprehensive evaluation.

Most of the rehabilitation centers presently serving deaf clients

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* Title I provides increased support for the P.L. 89–313 program for the handicapped. Under the Elementary and Secondary Education Act of 1965, "State agencies will receive a maximum grant for the children they are educating through state-operated or supported schools. In fiscal 1968 this amendment will provide . . . additional funds for new personnel, instructional materials, and other programs."

Title III earmarks 15 per cent of the $30 million available July 1, 1968, to support "innovation and implementation of the newest in educational methodology related to education of the handicapped."

Title VI "authorizes participation of children on Indian reservations . . . in its grants-to-States program for improvement of education of the handicapped." Also, "the program for research and related purposes in education of the handicapped was extended and expanded to include authority to conduct research and to award contracts for research, in addition to the grants which previously had been awarded."

(Quotations are from *New and Expanded Programs for Education of Handicapped Children Authorized in 1967*, a pamphlet issued by the Bureau of Education for the Handicapped, U.S. Office of Education, Department of Health, Education, and Welfare, 7th and D Streets, N.W., Washington, D.C. 20202.)

† A listing of rehabilitation centers serving multiply disabled deaf clients can be found in Appendix A.

are conducted along the same *general* lines as a pilot research and demonstration project undertaken in Lansing, Michigan, during 1961–65. This project was administered within the already existing Michigan Association for Better Hearing. An inter-disciplinary team included instructors specially selected for their skill in communicating and working with low-verbal deaf persons, agency personnel who had received short but intensive training in this area, and outside consultants. Clients were referred to the project from various sources. The psychologist was responsible for obtaining social, psychological, and educational background information on each client prior to admission and for the initial assessment of client intelligence.*

An evaluation profile was drawn up on each client, based on both objective and subjective data obtained over a period of time. Initial subjective data included observation of social responses, emotional stability, language facility, and so on. Objective data from tests included reading achievement, writing ability, manual communication skills, and other measurable aptitudes. The profile thus developed served to guide the counselors in their handling of each case.

Services provided include group counseling, work experience, and instruction in language and communication, daily living activities, occupational information, and job adjustment. This prevocational training was aimed at preparing clients for on-the-job or trade school training or for direct placement. Work evaluations made during the course of the program seemed to be good indicators of individual ability and vocational success (10).

The rationale for selection of an appropriate facility or center will depend on the following possible client needs in terms of available services and therapy: a multi-disciplinary team approach; treatment in a sheltered environment; group living experience; highly specialized training and/or corrective resources; removal from his present environment and provision of an environment offering different peer, supervisory, or other influences.

Techniques

As with all rehabilitation clients, the comprehensive evaluation of a deaf client begins with a physical examination. It may be necessary for the counselor to arrange for an interpreter to be present at the examination, and this contingency has been pro-

* This project accepted only male clients of average or superior intelligence as tested on performance scales. Other centers do not necessarily make the same restrictions.

vided for by P.L. 89-333, which permits the payment of fees for such services with federal funds.

The comprehensive evaluation will include an audiometric examination and an assessment of the client's communication skills, oral, manual, or written. The feasibility of auditory training and/or speech and lip reading therapy may arise, but the counselor should proceed cautiously in following up recommendations for such training, since it is appropriate in only a limited number of cases.

In psychological assessment the counselor must rely on the skill of the psychologist he chooses. Since each psychologist has his preferred tests and methods and since communication methods often affect diagnosis of the deaf person, results may vary widely. If no psychologist experienced in working with deaf persons is available the counselor will need to make a careful choice. Among the specific tests the psychologist might use are the Thematic Apperception Test, the Weschler Intelligence Scale (Adult and Children), the Nebraska (Hiskey Non-Verbal) Test of Learning Aptitude, the Leiter International Performance Scale, the Ontario School Ability Examination, the Bender Gestalt Visual Motor Test, the Crawford Small Parts Dexterity Test, the Rorschach Ink Blot Test*, Ravens Progressive Matrices, the Geist Picture Interest Inventory: Deaf Form, Males. The performance sections of the U.S. Employment Service's General Aptitude Test Battery are valid indicators of functioning ability but the general, verbal, and number scores often cannot be accurately obtained. These tests will provide clues as to the client's self-image, organic brain dysfunctions, and learning capacity as well as intellectual ability and emotional adjustment. The counselor should press for a battery of tests to cover personality, since single performance tests now in use do not give an adequate picture of mental ability and adaptive behavior in the deaf person, especially one with multiple disabilities. Evaluation of psychological tests for deaf persons is available elsewhere in the literature (3).

In assessing the results of tests, especially those related to vocational interests and potential, the counselor should be concerned with more than paper tests. It is possible that the client needs more information on the choices open to him before he can reach a realistic decision. Limited knowledge and experience results in unrealistic goals for many deaf individuals.

Evaluation will also include an in-depth study of the client's social history by a social worker or an assigned counselor. This

* Clinical usefulness of Rorschach Test findings depends on rapport between subject and tester; hence, sufficient communication for good rapport is essential if this test is used.

study will incorporate information about his family, school records (including those on behavior, which should be used mainly for comparative purposes), personal factors (appearance and attitudes), social activities and associates, community adjustment, and interests to be developed, such as hobbies and his relationship with the opposite sex.

Together with the data on vocational background and goals, this information will serve as the basis for determining remedial treatment or counseling, or it will help in choosing the type of training and the situation for it.

TRAINING

Social Adjustment

In order to achieve maximum rehabilitation, the deaf client, and particularly the multiply-disabled deaf client, may first require help in changing many aspects of his behavior. Across-the-desk counseling alone cannot be expected to effect the needed change. Change is more likely to be realized through a program of structured experiences designed especially for the purpose of adjustment, both social and personal. Training is most easily accomplished within the rehabilitation centers. The counselor working alone may initially need to delegate much of the work to foster parents or to volunteers from both hearing and deaf communities.

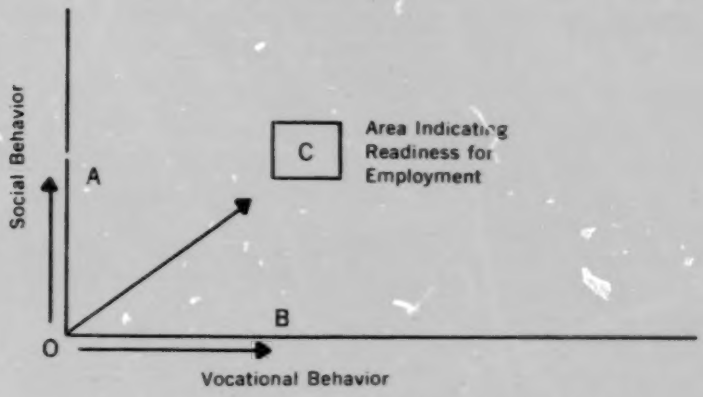
Social adjustment training* may usually be initiated prior to a program of vocational skill training but often may also need to be provided concurrently with the skill training. The goals of adjustment training services are to assist the client in reaching his peak of acceptable social and personal behavior and to raise his level of self-esteem in order to develop improved patterns of social and vocational behavior. With each client, the counselor responsible for training must decide what behavior is to be encouraged and what discouraged, and he must guard against unknowingly reinforcing negative behavior patterns.

An adjustment training program is not likely to be effective if the facility counselor's caseload of clients numbers more than 20. Ideally, he should serve no more than 10 such clients at any one time. Close work with the client and coordination of staff efforts is a requirement for success. After good rapport has been established with the client, it must be maintained by ensuring that he, as well as staff personnel, is aware of progress made. This is

* The most effective training procedure is the Adjustment to Daily Living program outlined in a later section (p. 43).

especially true of the deaf client, who does not readily obtain information. The counselor should make every attempt to obtain the client's cooperation in establishing short term and long range expectations for a step-by-step series of training goals. It should be emphasized that structuring the client's experiences does not mean total manipulation of the client. Some permissiveness will enable him to utilize his internal resources to adapt to the structured environment, which will often be therapeutic in itself so that the client can improve in many areas of behavior with little supportive assistance.

The graph below was developed in the rehabilitation program for the deaf at the St. Louis Jewish Employment and Vocational Services. It illustrates the significance of both social and vocational behavior in determining readiness for employment.



1. Upward movement along line *A* represents improved social behavior.
2. Movement to the right along line *B* represents improved vocational behavior as noted in a workshop setting.
3. Progress to area *C* is to be achieved through adjustment training services.

Among the services and techniques that will contribute to improved social behavior are: development of the client's communication abilities and provision of other treatment and restorative services as needed to raise his self-esteem; structured activities for initially limited and then progressively greater degrees of responsibility;* use of therapeutic devices such as group counseling and role playing; use of visual-aid media, including loop-film (one-concept) movies illustrating acceptable and unacceptable be-

* A task should never be beyond the capacity of the client. Success at each level of adjustment is part of the therapy.

havior in others; and candid photographs and videotape replays to allow the client to observe his own behavior. (For information as to the availability of visual media and equipment write to Media Services and Captioned Films, U.S. Office of Education, Department of Health, Education, and Welfare, 7th and D Streets, S.W., Washington, D.C. 20202.)

Pre-Vocational Training

Pre-vocational training programs for the deaf are available in a number of rehabilitation centers. The programs aim at leading the client to the highest possible skills such as essential communication, traveling in the community and following through to the formation of acceptable work habits. Work conditioning, that is, building up a physical and psychological tolerance for sustained work, is achieved by the provision of routine tasks such as packaging, assembling, collating. Adjustment training is extended here to include the development of proper and acceptable peer and supervisor relationships in the shop.

The counselor concerned in this phase of rehabilitation must work closely with workshop personnel and have realistic goals for his client. He must accept the possibility that this will need to be a long-term program and realize that some clients may never be able to work competitively.

Vocational Skill Training

Skill training may involve an on-the-job program, a local rehabilitation facility, a local trade or business school, regional centers where training is offered, or some form of college training. The counselor dealing with a large number of deaf persons will need to explore the various resources in his community and in the nation and evaluate their effectiveness for his clients. Rehabilitation centers will normally include a recommendation for training, if advisable, in their evaluation report and will usually undertake to arrange for or provide such training.

The needs of multiply disabled deaf persons will vary so greatly that generalizations are impractical. Special considerations for clients with the types of secondary disabilities under discussion are set out in the separate sections.

PLACEMENT

The counselor who handles his own placement services will be familiar with the customary sources of employment leads in the

community. These include the State employment service, government programs at various levels, all tax-supported agencies, and previous DVR-employer contacts. The client's parents, local hospitals, and various sheltered workshops may also prove helpful. For the deaf client the counselor might usefully investigate openings in Federal Civil Service programs for the severely disabled (non-appropriated funds) and the possibility of similar programs being set up by county officials. Assistance in locating and developing jobs may also come from employ-the-physically-handicapped committees (governor's or mayor's committee).

Development of job opportunities is largely a matter of public relations. Counselors need to schedule time for this sort of field work. Publicity spots in various media may be secured; tours of service facilities for multiply disabled people can be organized for reciprocal learning (although these may backfire if some individual employers develop negative reaction to the disabled persons they see). On-the-job training can be a lead to placement. A survey of deaf persons in the area will secure a list of employers who have hired deaf persons and may thus be receptive to hiring multiply disabled deaf clients. From such a list it is possible to develop industry personnel staff and a wide variety of industry resources. A person with trade or industrial experience may possibly be able to see opportunities not previously considered for the multiply disabled applicant.

In some situations a placement officer will assist in, or assume, placement responsibilities; in such cases the counselor and placement officer must be in close communication. A gap sometimes exists between the person or persons who have trained a client and the person responsible for placement. Here again communication is vital among the professionals serving a client.

Development of job opportunities may be fruitless, however, if the client is not properly prepared for placement. This means not only that he should have received the maximum possible adjustment and vocational training but that he should be ready for the initial encounter with the employer and the problems that may arise early in employment. He may need coaching in appropriate replies to application questions, or a sheet of paper on which his vital statistics and other pertinent information are set down.

The counselor should be aware of the psychological impact of difficulties in communication between deaf persons and their hearing supervisors or co-workers. If he is able to understand that frustration expressed by the hearing person may be no more than a reaction to embarrassment and uncertainty, he will be better able to assist in overcoming the awkwardness.

The employer who has not previously encountered a deaf per-

son will usually need some orientation. He should have some insight into the client's communication problems, including the reciprocal responsibilities he shares with his communicant in establishing an effective communication method (for example, communication with a deaf-blind person is tactile).

In presenting the multiply disabled deaf client to the employer, abilities should be emphasized and disabilities minimized to a point consistent with honest presentation. Placement might usefully be preceded by an evaluation of the attitudes toward various handicaps of the people in the work setting, employees and customers as well as employers. It will be helpful for the counselor to assure the employer he will assist in orienting the client to the job and that he will be on call as needed.

There are certain subsidiary activities which tend to insure and support proper placement. The counselor should cultivate information exchanges with supervisory personnel and fellow workers of the client. Housing is an important consideration for effective placement. Halfway houses may be available as a resource or assistance may be secured from unions, neighborhood youth centers, or youth opportunity centers. Schools for the deaf may, in some instances, be in a position to offer assistance in providing or locating housing. Housing is related to transportation. Where does or will the client live in relation to the place of employment? What means of transportation are available? Relocation of the client's living area may be a prerequisite to employment. Relevant to these problems are those of food, recreation, social environment, and access to friends. The approach in regard to these elements should be to prevent them from creating problems so great as to interfere with job performance.

Points to be kept in mind for successful placement procedures are:

Proper preparation and study of the client.
Proper organization of community resources.
Proper orientation of both client and employer.
A realistic approach to cost.
Don't forget communication—ever!
Realistic planning and good staffing.
Obtain feedback for use in future work.

FOLLOW-UP*

The goals of follow-up with multiply disabled deaf persons should be dual: the usual goal of insurance of suitable employ-

* The various discussion groups' conclusions about follow-up have been consolidated in this single section because the findings are applicable regard-

ment and a further, concurrent goal of maintenance and improvement of social and emotional adjustment. The aim should be productive and effective living through helping the client to improve his general capacity to function vocationally and socially (7). Such follow-up should occur not only after a placement in work but should be a concurrent activity throughout the rehabilitation process.

Follow-up must include also an evaluation of how the client is adjusting to the community as well as to the job. It must also be remembered that the counselor is working with the client within a family relationship and must consider *them* as well as *him*.

Vescovi expresses the concept of follow-up as:

> This is another way of saying that, if we are really interested in helping change for the better the behavior of the multiply disabled deaf client we should be ready to follow up each service given him, e.g., after a specific diagnostic test or exam, after one—or more, depending on each client's situation—counseling or tutoring session, and during different phases of personal adjustment, prevocational, vocational, and on-the-job training (11).

Such follow-up serves to determine if the services have caused new learning to take place in the client, his family, other persons close to him, and other systems that may have a significant claim on him. It also serves to reinforce the positive changes which inhibit negative reactions. It gives reassurance and security to the client to know that the counselor is truly interested in him.

Concurrent follow-up is often the only feasible approach to working with multiply disabled deaf clients. They are frequently "overly dependent, immature, inexperienced, fearful, and it may be added, resistant to change." (11) Hence the rehabilitation process may require radical changes in self-concept and behavior. Hampered by underdeveloped personal and social skills, the multiply disabled deaf client will often be faced with crisis situations. It is not likely either that multiply disabled persons, who often have been conditioned by people doing things for them, will face up to or resolve these crises. They will look to other people to handle crises, or they may withdraw from them. The good counselor will be available to help when needed, but he also will endeavor to build up the self-concept of his client. He must allow the client to do what he is capable of doing. As the client progresses, the counselor will do less, but with the client's limitations in mind, too.

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less of what the secondary disability might be. The follow-up technique is similar for any deaf person; its variation for the different disabilities will be a mattter of degree and of the elements of the situation.

Follow-up with the multiply disabled deaf client also will be more necessary because

> The multiply handicapped deaf are a devalued group. Their physical and mental disabilities and functional deficiencies are highly visible and often cause them to be rejected by their own families, by other deaf people (the more competent), and by society at large. (11)

And, it may be added, by non-deaf persons having the same secondary disability.

Because multiply disabled deaf clients require extended evaluation, services, and follow-up, funds for this type of service are available under Public Law 89–333. The counselor and the evaluative agency should investigate this source of support.

Situational Procedures

One view that may be taken of follow-up is in relation to the social situations or institutions in which the client is placed.

Concurrent follow-up may be especially effective while the client is still in a school or class for the deaf. Follow-up services at such a time reach their greatest value to client, family, and school. The client is then young and more malleable.

Concurrent follow-up is of especial value to institutionalized multiply disabled deaf persons, faced as they are with the threat of complete isolation. The counselor then becomes liaison for the client with family, friends, the deaf community, service agencies, and former and future employers. Intensive follow-up of hospital and post-hospital services will make the transition back to community more rewarding.

When a client is being served by an evaluative workshop, the counselor follows up in order to evaluate the services being provided. He should act as a feedback to the evaluators of the results of their procedures and recommendations. Finally, the counselor must help to determine when the client is ready for a move into training or placement.

When the client is in a sheltered workshop, the counselor can follow up by encouraging the workshop to make use of professional staff and other resources to help the client in the adjustive process. The counselor should make continuous check on the possibility of client movement to a higher work setting.

Placement in either type of workshop does not mean that the counselor's work is done and follow-up is unnecessary.

Finally, there is vocational follow-up, insurance that suitable employment has been obtained. Counselor services should be available on a pre-crisis basis to avoid possible unnecessary re-

missions. Employer education should be maintained on a continuous basis. With a multiply disabled client the counselor must draw a fine line between challenge beyond the client's limited capacity and overprotection that dulls growth and adjustment. Particularly in follow-up the counselor must beware of underemployment. Many times the underemployment will not become apparent until some time after the client has been placed, due to his growth as he works at that job. The first, or even second, entry level should not be considered as the final level of employment. Follow-up should also include reassessing the jobs in a particular plant in accord with the rapid changes occurring in modern industry.

The counselor should ask the employer of his multiply disabled deaf client to inform the agency office if another similarly handicapped person applies for work there. Ther counselor may be aware that the applicant possibly represents a danger to the job of the client already placed and to the employer's image of workers with similar disabilities who might later be appropriate for job openings. He should be alert to problems created by groups of deaf people in the same plant. Successful placements can open doors to more placements and an unsuccessful one can close the door.

Counselor Responsibilities as a Function of Time

The usual 30-day follow-up is insufficient for deaf clients, even less sufficient for multiply disabled deaf clients. Three months should be considered the absolute minimum; perhaps one year would be realistic with multiply disabled deaf persons. Actually no time limit can be stated as the amount of time the counselor is to spend on a case. He must decide when to close the case, be it with a steady job or with transfer of the client to another agency, i.e., a church, welfare agency, social service, or the like.

There is a periodicity to the counselor's follow-up activities. In the initial period he will be concerned with such social adjustments as residential living changes and modifications, transportation, evidence that the client is not reacting constructively to the stresses of the new situation. At this time, the counselor will be interested in the quality and quantity of the client's work, his orientation to general work conditions and to the physical environment, architectural barriers, and the like. Also of concern will be the provision of pertinent information about the client to the employer and, importantly, the establishment of communication between the client and supervisors and fellow workers.

As a continuing responsibility, follow-up looks to the client's

social and vocational adjustment and growth. The counselor may help to introduce the client into the deaf community and assure that continuing family aid is available to the client for his best adjustment. The counselor may also be called upon to assist the client in fulfilling his responsibilities regarding taxes, unions, insurance and in planning for such needs as medical care, driver training, car purchase, emergency situations. The client may also need help in relations with supportive elements in the community (landladies, ministers, social agencies). The counselor needs to maintain as much employer contact as the individual client situation requires and the job site allows. He must transmit to the employer needs which the employee cannot himself express; he must also be alert to assist in vocational upgrading of his client.

Over the long run, social follow-up entails the client's continued progress toward independence and absorption into the general and deaf communities and the work community. Included in this responsibility are preventive mental health measures that will assist the possible gradually deteriorating client to return for professional regenerative services through the rehabilitation process. As regards the vocational scene, the counselor needs to be aware of potentialities of the client's present job for future employment—i.e., is the job relatively stable or more likely to be transitory? Also is the client himself relatively sound physically or will anticipated physical deterioration diminish vocational skills? The counselor needs to be aware, for future planning, of the image the employer is developing about deaf people in general.

Personnel and Resources in Follow-up

The counselor need not do all of the follow-up himself; supportive personnel in the community where the client is working can assist with the time-consuming routine work of follow-up contacts. Deaf persons can provide supportive environment and ease the communication difficulties of language-deprived clients; service-motivated hearing persons can be trained for volunteer assistance. Registered interpreters should be recognized as important liaison persons between deaf and hearing individuals and groups. Social workers and religious workers can be helpful by providing around-the-clock crisis service. Finally, established and experienced counselors for the deaf can be of great assistance to new workers in the field.

The counselor serves as a recruiter, promoter, and coordinator of the various community resources for the task of follow-up. He should establish a systematic identification of all available service

organizations. He must coordinate their activities on behalf of his clients. For example, part of this coordination lies in keeping all those who are interested in a particular case (referring agencies, training facilities, professional people, and so on) advised as to the progress of the client—not just notification of closure but adequate follow-up information.

Follow-up with Multiply Disabled Deaf Persons and Less Handicapped Deaf Persons

Vescovi has expressed very clearly the difference in follow-up needs of the more competent deaf person and the one who is deaf and multiply disabled:

> Do follow-up procedures for the "normal" deaf differ from those needed for the multiply handicapped deaf? The question is, of course, academic, as would be any question which refers to the normalcy or non-normalcy of the deaf. The question is raised here and dealt with only briefly.
>
> What interests us primarily is the fact that some deaf people have multiple problems in living and in self-regard and cannot cope with them effectively. They either have never learned to or have not learned to do so well enough. They must be helped to learn or re-learn how to cope effectively within their capacities. With the multiply handicapped deaf, then, follow-up must be an intensely involved relationship between the multiply handicapped deaf and counselors and other staff who undertake to "teach him." It is also an ameliorative and adjustive service.
>
> On the other hand, there are deaf people who may have multiple problems in living and in self-regard that are of much less intensity and frequency than those of the multiply handicapped deaf. They are not affected as deeply because they are not threatened as often or as deeply. Hence they can cope with these problems with less effort (provided they do try) and more success. Follow-up with them is only minimally ameliorative or adjustive but should stress support, encouragement, and guidance. (11)

CHAPTER 2

The Mentally Retarded

IDENTIFICATION

Mental retardation may be described broadly as "an inadequacy of general intellectual functioning which has existed from birth or childhood." (4) On the most commonly used tests of general intelligence, an arbitrary cut-off point equivalent to a test score of about IQ 84 is set, and the individual scoring below this point comes under *consideration* for possible retardation. It has been recognized, however, that current tests of general intelligence do not predict with full accuracy the level of a person's adaptive behavior. Since "it is the deficiency in adaptive behavior, not a subaverage test score, which draws society's attention to an individual and creates a need for social or legal action on his behalf . . . the official definition of the American Association of Mental Deficiency requires that a suspicion of mental retardation established on the basis of measured intelligence be confirmed by a clinical judgment as to the individual's actual adaptive behavior." (4)

Adaptive behavior is considered adequate at the adult level if the person is able to maintain himself independently in the community or to meet basic performance standards in employment when presented with the opportunity to do so. "In practice, few persons near the cut-off point in measured intelligence are diagnosed as mentally retarded inasmuch as their adaptive behavior is not called into question. As measured intelligence becomes lower, increasing percentages of persons are identified as mentally retarded." (2) Current usage favors a classification in terms of four levels of impairment in adaptive behavior; mild, moderate, severe, and profound. Only individuals at the fourth level are considered incapable of any kind of productivity whatsoever.

Kirk has expanded upon this definition in terms of potentials for training:

a. The Slow-Learning—Those who are not considered mentally retarded because they are capable of achieving a moderate degree of academic success even though at a slower rate than the average child. They are educated in the regular classes without special provisions except an adaptation of the regular class program to fit slower learning ability. At the adult level they are usually self-supporting, independent, and socially adjusted.

b. The Educable Mentally Retarded—Those who, because of slow mental development, are unable to profit to any great degree from the programs of the regular schools, but who have these potentialities for development: (1) minimum educability in reading, writing, spelling, arithmetic, and so forth; (2) capacity for social adjustment to a point where they can get along independently in the community; and (3) minimum occupational adequacy such that they can later support themselves partially or totally at a marginal level. The term "educability" then refers to minimum educability in the academic, social, and occupational areas.

c. The Trainable Mentally Retarded—Those who are so subnormal in intelligence that they are unable to profit from the program of the classes for educable mentally retarded children, but who have potentialities in three areas: (1) learning self-care in activities such as eating, dressing, undressing, toileting, and sleeping; (2) learning to adjust in the home or neighborhood, though not to the total community; and (3) learning economic usefulness in the home, a sheltered workshop, or an institution.

d. The Totally Dependent Mentally Retarded—Those who, because of markedly subnormal intelligence, are unable to be trained in self-care, socialization, or economic usefulness, and who need continuing help in taking care of their personal needs. Such children require almost complete supervision throughout their lives since they are unable to survive without help. (5)

The definitions above refer to the diagnosis of mental retardation in persons with normal hearing. Where the deaf client is concerned the vocational rehabilitation counselor will need to be even more cautious in making an initial identification of mental retardation. It may be difficult for him to distinguish between educational retardation and basic mental retardation. He may also be misled by the poor speech and inadequate spoken or written language of his client. In general, where retardation is suspected the counselor is well advised to seek professional diagnosis. However, the difficulty of obtaining an accurate evaluation is compounded by the lack of diagnosticians trained in working with deaf persons. The client's inadequate communication skills may often adversely affect the diagnosis; on the other hand, he may be rated higher than expected when tested under conditions of optimum communication.

The counselor should also be cautioned against assuming that normal intelligence is present where a client has been graduated from a school for the deaf. He may find, too, that deaf individuals graduating from special classes in the public schools may have exaggerated ideas of their own educational achievement. A client's ability to communicate through hearing and speech may distract the counselor from an underlying retardation problem.

For the school-leaving deaf client, the counselor can be fairly safe in assuming mental retardation if test scores are accompanied by the evaluation of a good teacher. The problems of testing deaf clients are discussed on pages 19–20; a list of tests commonly used is included there.

Besides finding mental retardates among referrals from schools and classes for the deaf, counselors may be alert to the possibility of discovering mentally retarded deaf clients:

In the drop-out lists

Many schools for the deaf dropouts may be mentally retarded.

In schools for the mentally handicapped

Deafness may have been overlooked or minimized among pupils at public or private schools (day or residential) for the mentally handicapped.

In the institutions

Deaf patients are often misdiagnosed and placed in institutions. The counselor could encourage periodic reevaluation of deaf institution inmates by the staff for referral to professional personnel. He should be particularly aware that poor adjustment in an institution does not necessarily preclude good adjustment in the community; conversely, the individual who is well adjusted by institutional standards may have great difficulty outside.

Among deaf persons diagnosed differently

Emotional and other problems may obscure retardation.

Clues that may lead the counselor to suspect retardation where no test scores are available include a sketchy language pattern (whether manual or oral); the client's being in a manual setting although his audiogram suggests hearing ability and potential for speech; the nature of the client's association with his deaf peers (probably very limited or superficial). Where the family of a deaf client has moved him from school to school and later contacted several different agencies or where the family relationships are poor, mental retardation may be a factor.

Other agencies in the community serving mentally retarded deaf persons may provide referrals. A public relations program could help the counselor contact such agencies. More importantly,

it could help to eradicate the stigma attached to persons with this dual handicap.

EVALUATION

The counselor must realize from the start that working with a mentally retarded deaf person will be more time consuming than with the ordinary rehabilitation client. It is anticipated that after the counselor has interviewed a large number of mentally retarded deaf persons, he will find that many of them have other handicapping conditions as well. There might be a whole complex of problems.

Even if the client can be enrolled in an evaluation center, it would not be realistic for the counselor to expect as many closures when dealing with deaf retardates as he would with less handicapped individuals. Extended evaluation will be needed, and Federal funds are earmarked for this purpose.* The counselor's superiors should normally be aware of this and support him by relieving any pressure to attain a specific number of closures. Counselors may, in fact, be induced to accept mentally retarded deaf clients by a reduction in their total case load.

Practices and Procedures

The initial interview with a mentally retarded deaf person should focus on information to be gained concerning the client. The client must be made to feel that the counselor is vitally concerned about his problems and his self concept. He should be encouraged to talk about himself, and be assured of the counselor's attentiveness. As a rule, the mentally retarded deaf person will have been told what to do and what is good for him, and thus will be exceptionally dependent.

It is completely logical to assume that mentally retarded deaf persons are not receiving adequate examinations due to their lack of language facility. For example, in physical examinations the client may be unable to describe his ailments; in optical examinations he may not be able to communicate vision deficiencies; in vocational evaluations the client may have no knowledge of the kinds of jobs that are commensurate with his abilities and limitations. The counselor will need to ensure that adequate interpretation is provided to assist in the rehabilitation process.†

* Public Law 89-333 provides for evaluation periods of up to 18 months.

† Public Law 89-333 provides for interpreters for deaf people as a rehabilitation service.

Apart from this, the process of rehabilitation of the deaf retardate is similar to that used with the non-deaf. The counselor will need to make certain assessments, including how severe the client's limitations are, what assets he has, where he should be placed for evaluation and training, and where and when he should be placed for work. The counselor continues to be the key person in the total process and must work with the client and his family in determining a course of action—a vocational objective.

Communications experts for multiply disabled deaf persons are available at the evaluation centers listed in Appendix A. The counselor with limited manual communication skills will usually prefer to enroll his client in such a center, which will then present him with the information necessary for further action. It will be the counselor's responsibility to decide whether or not to make use of an evaluation center and how to use the reports that are submitted.

Once the counselor is acquainted with the various centers he will be able to choose the center best suited to the needs of his individual deaf retarded client. In determining these needs, he should be guided by his observation of the client's personality and background. Is he exceptionally shy or withdrawn? Does he display passivity and lack of interest in his surroundings? Are his communication skills severely limited? What personal and social problems are indicated? For example, how well is he accepted by his family? What previous vocational successes or failures has he experienced? The answers to the above will need to be checked against the entrance conditions and services offered by the different centers. Evaluation at a center may have its limitations in certain cases.

Because of the overprotection often given to the mentally retarded deaf person, there may be some resistance from the client or members of his family towards enrollment in a center. It will be part of the counselor's task to help them see the need for the information that can be obtained.

Where evaluation services for the deaf are not readily available, or where the client is considered too handicapped for enrollment at an out-of-town evaluation center, the counselor will need to take much more initiative in effecting evaluation. He should be prepared to see the client more frequently than he would a less handicapped individual, and to continue counseling over a longer period. It may be that a sheltered workshop will be a first step towards self-realization for the client and his family. The counselor may wish to approach private employers, who are sometimes willing to provide on-the-spot evaluations.

The counselor can use local specialists in mental retardation to

assist him in dealing with the client. A resource person from this area could work in conjunction with a specialist in the area of the deaf to help the counselor in planning individual programs. He can also use the local, State and national organizations concerned with mental retardates. Much free service and advice is available at the local level to help the counselor. The names of organizations or resource persons are generally readily obtainable. Some States also have a resource manual describing the services of centers, workshops, and other facilities that the counselor might use.

The Developmental Evaluation Center at Central Colony in Madison, Wisconsin, is an example of the kind of resource program that might be utilized. Here, extensive evaluations are made by means of a multi-discipline approach. A method of evaluating clients by using video-tape has been evolved; the client is taped in his initial performance of specific tasks, behavior modification is then attempted, and performance is retaped at a later date. This enables an accurate evaluation of adaptability and flexibility to be made. The Wisconsin facility is adult-client oriented and is specifically for the mentally retarded. Up to this time it has not been used for deaf persons. The counselor might usefully encourage administrative exploration with regard to the establishment of a similar center in his State, if none exists.

As previously noted, there is a severe shortage of psychologists who are adequately trained to evaluate deaf persons. The problem is intensified when the person to be tested is also retarded. At present there are only three training centers for psychological evaluators of the deaf in the nation. The growing numbers and demands of multiply handicapped deaf persons make expansion of such programs imperative. It is suggested that where no suitable diagnostician is available the counselor might interest a local psychologist in working with deaf clients. Such a person could then avail himself of the specialized training offered at one of the training centers, which are located at New York University, and the University of Pittsburgh. (Addresses are available in Appendix A.)

More can be done in staff development in the rehabilitation offices to increase the counselors' ability to work with a multiply disabled deaf clientele. Members of the local deaf community could be used to teach manual communication to the staff, and to give the staff more insight into problems associated with deafness. Local and State associations for the deaf can provide the counselor with information on services available to deaf retardates. The Council of Organizations Serving the Deaf* and the

* 4201 Connecticut Avenue, N.W., Washington, D. C. 20008

National Association of the Deaf† willl also be able to supply information on special services available at the State and national levels.

The TOWER Evaluation System

The TOWER system has been found useful in evaluating deaf persons, including retardates. It has been used, notably in Tennessee, with clients who are more severely handicapped. The system is an objective evaluation of work skills based on the use of work samples.

In setting up these work samples, local industries can be utilized. A specific sample is obtained and questions are asked of industrial personnel as to the evaluative quality of the work; e.g., Why is this a superior or inferior piece of work? What amount of time is required to produce it? From the answers so these and other questions a work sample is built. If reading is necessary during the production of an item then reading is built into that particular work sample.

The TOWER test includes a variety of standardized work samples that can be used and it can be adapted for testing various types of work skills. It is a flexible instrument.

The client is given background information on the various tasks. If he is interested in one kind of work, he is tried out and his efforts are measured and compared against commercial standards. It has been found effective to have the client live away from the school or agency and come to "work" daily while he is being tested.

Because of its applicability to local conditions this system helps in public relations with local industry. It makes employers aware of multiply disabled persons in the community and also serves to train these persons in locally-needed industrial skills and practices. Since mentally retarded persons are capable of certain types of industrial jobs and learn best from repeated and simplified experience, this system is a useful, if limited, tool in the evaluation and training of deaf retarded clients. A more detailed description of the system and its use with deaf persons is available. (8)

TRAINING

How do programs for training deaf retarded persons differ from those for non-deaf retardates? The major difference is in the means of communication used. Current programs for the

† 905 Bonifant St., Silver Spring, Md. 20910

non-deaf retarded emphasize instruction through the spoken word and minimize the need for reading and writing. With deaf retardates, communications skills are generally so limited that even the language of signs is insufficient for establishing rapport in the initial stages. Often, vocational training will need to be postponed until the client has, through the development of improved self-awareness and empathy, achieved more meaningful communication with the training personnel. This improved skill must then be used as a basis for more formal instruction. The process prolongs the training period but is unavoidable if rehabilitation is to be furthered.

Especially among long-term institution clients, the counselor should be alert for individuals who have been labeled mentally retarded but who are actually educationally retarded. These individuals may begin with no apparent communication skills and in the initial stages of training be withdrawn and apprehensive but, given the right program, will suddenly emerge from their shells and make satisfactory progress thereafter. With these and other retarded clients it may be necessary to use the services of several agencies in a succession of steps to arrive at a positive solution. Evaluation and reevaluation occur at each step.

The counselor should, in fact, be cautious about labeling any of his clients as retarded when considering training. It must be remembered that three per cent of the total general school population is classified as retarded under the stringent demands of an academic environment. In the adult population this percentage is smaller, owing to the number of individuals whose adaptive behavior is adequate or better. It may be assumed that the same will be true of the deaf population, and that a large number of deaf persons classified as retarded by the schools will, in the community, improve their personal and vocational skills to the point where they move out of the retarded classification.

Personal Training

For the deaf retardate, personal and social skills are more important than vocational skills in the initial phases of training and in the total rehabilitation process.* Without them, he will be unable to retain employment even in jobs that are commensurate with his ability. The different centers vary in their ability to provide training in these skills.

Adjustment to the community is the first stage in such train-

* For this type of client, the most suitable training program in these skills is the ADL (Adjustment to Daily Living) program referred to elsewhere in this manual (p. 43).

ing. Frequently, especially with institutionalized clients, some kind of home placement will be necessary. Halfway houses serve as bridges between institutions and the community; where none is available to serve the needs of his client the counselor may wish to encourage the establishment of one similar to those existing for other handicapped conditions. Foster homes have been used successfully in several areas. However, the counselor is cautioned to investigate carefully the home situation, including the stability of the family relationship, before making a placement. This is especially true where the foster family is deaf and the client will be more aware of what is being said. Unstable marital relationships in the foster family may threaten the client's future marital adjustment. Deaf persons are more like the general population than they are different from it and need wholesome environments in order to achieve their maximum potentials.

The counselor will want to see that his deaf retarded client receives training in acceptable behavior for social adjustment and in group living situations. Captioned films should be available to help in such training. The Social and Rehabilitation Service is presently conducting a State by State survey of immediate and future needs in the area of training media, and funds based on State recommendations should eventually be available.

An important part of the training program for the mentally retarded client will be introducing him to the various community services and agencies that he will need to use, such as the Social Security office, health services including hospital clinics, and so on. A necessary element of the total rehabilitation of such a person is the inculcation of a sense of independence by providing him with these community contacts.

Social adjustment to the deaf community as well as to the community at large should be part of the over-all plan. Counselors should consider buying the services of deaf persons capable of working with mentally retarded deaf people in developing their training, community, and vocational adjustment potential.

Vocational Training

It should be stressed again that there should be a continual reevaluation of the mentally retarded deaf client throughout the training and counseling process, that labels should be avoided, and that the retarded person be given every opportunity to succeed.

It is best to look at the client's present functioning* and start

* As indicated during the evaluation process by the TOWER or other systems.

the rehabilitative process from there. The counselor should see that the steps in the training process are as small as possible. In building up vocational skills the client should be started on small tasks which make up a much larger task, and he should go through a graduated series of assignments, from simple to more complex. The value of positive reinforcement should not be forgotten. Even severely retarded deaf clients have been shown to succeed under such structured conditions. Motivation in these persons develops chiefly through being on the job, working for money, and associating with others as equals. If such a situation can be found or set up, the client will be motivated to learn job skills and will do so within his limits.

In determining appropriate vocational training areas for mentally retarded deaf clients, the counselor should be guided by the industrial potentialities of the particular community. It is more reasonable with this type of client to fit him to the jobs that are or may be available than to train him for a specific trade that may not be appropriate for the time or for that geographical area. However, if apprentice training is desired, information and advice might be obtained from local, State, or national branches of the Association for Retarded Children.

The federal government is a prime employer of the handicapped and has special procedures for hiring the mentally retarded. Local conditions may be investigated for training possibilities.

Some hard-to-fill jobs, such as those where noise is a deterrent to non-deaf employees, may be useful areas to explore. Studies of occupational status and employment often contain lists of jobs in which deaf persons have been successfully placed by the counselor.

PLACEMENT

Placement for the mentally retarded deaf client may be divided into community placement and job placement, since the counselor may need to concern himself with both areas.

Community Placement

Reference has already been made to certain procedures in the home placement of clients without families of their own (see p. 30 & 31). Where clients with families need to live away from home in order to work, it is important that each family be involved in, and understand, any arrangements that are made.

It may be part of the counselor's responsibility to investigate the living conditions of the boarding home or apartment into which the client moves. He will usually need to warn the home owner or landlord what to expect in the way of atypical behavior and problems. He should, at the same time, emphasize in the community that the mentally retarded deaf person is not representative of all deaf persons.

It will be important for the deaf retardate to be aware of community resources for help and for leisure time activities. In the community at large, a good local contact working on the lines of the Big Brother principle can be very useful to the counselor. Other resources that may be explored include the YMCA, sheltered workshops, charitable organizations, and service clubs.

Leisure time activities are an integral part of the total rehabilitation process and the retarded person will in most cases prefer to associate with other deaf persons. Resources for the counselor, especially when the client is placed out of town, include the State or local organizations for the deaf, interpreters, groups and church associations. These groups may provide names of members who are willing to serve as volunteers or supportive aides during the adjustment period.

Vocational Placement

Vocational placement is the main objective of the counselor. Although some deaf retardates will be found unemployable, the majority, with proper placement, should be able to remain on the job. A large number of non-deaf retardates have attained stable employment after suitable work adjustment training. Their deaf counterparts, through the development of healthy work attitudes, should be able to impress employers enough to be retained in permanent positions.

These positions, however, may be on a lower level of social acceptance than the client or his family are at first expecting. It should be the counselor's long-term goal to work for greater social acceptance of certain types of employment at levels that are commensurate with the abilities of deaf retardates. Meanwhile, he will need to help the client and his family achieve a realistic level of expectancy.

As already noted, initial placement in a sheltered workshop could provide the retarded deaf person with needed experience. This placement may occur even before evaluation at a specialized center, or the client can be upgraded directly from the sheltered workshop to competitive employment if performance so indicates. Goodwill Industries workshops may serve as good starting points

for this type of client. In several cities, including Milwaukee and Indianapolis, Goodwill provides programs for the deaf which include evaluation for on-the-job training and placement services.

In competitive placement, if the counselor can establish good rapport with certain businesses and industries he may obtain their cooperation for extended trial placements. These employers are likely to permit much longer adjustment periods for difficult cases, and will often accept special arrangements for deaf retardates, such as allowing trusted deaf employees to supervise their work.

Where there are no other deaf employees, the counselor may sometimes need to spend a short time actually pacing the client on the job, especially where the client is one who learns best by demonstration. The counselor could also usefully enlist a sympathetic co-worker to serve in a Big Brother capacity. This worker could be oriented to and alerted for problems the client might face in following schedules, adjusting to the building and routines, and knowing where to go for health services and other needs.

Among the points that the counselor will need to establish with the deaf retarded client at the time of placement and continue to stress through follow-up are: The identity of his immediate supervisor on the job (helpful in both adjustment and stability); a specific delineation of his duties; his wages and fringe benefits (it will usually be necessary to repeat this explanation frequently over a period); union membership and its ramifications for the client.

* * *

The topic of follow-up has been covered in the chapter on general principles and practices. The section concerned with follow-up may be found on pages 17–22.

CHAPTER 3

The Emotionally Disturbed

Defined in terms of behavior deviation, the emotionally disturbed person is one whose behavior not only has a detrimental effect on his development and adjustment but also frequently interferes with the lives of other people. A child is termed emotionally disturbed if he has inner tensions and shows anxiety, neuroticism, or psychotic behavior. The usual organic and or environmental causes of emotional disturbance are compounded in the deaf person by his severe communication deprivation, which may be partial, in that he can communicate with some persons in certain settings, or complete, in that he is unable to communicate either with other deaf persons or with non-deaf persons.

For the counselor who has had little experience in working with deaf persons certain cautionary statements are necessary in relation to symptoms suggestive of emotional disturbance. The counselor needs to understand the language and communication problems of the deaf person. Without such knowledge, he may be given the impression that many of the deaf clients he interviews, especially those with profound congenital deafness, are seriously disturbed. Deaf persons with no opportunity to relieve frustrations verbally may show symptoms of maladjustment. If the counselor is to work successfully with such clients he will need to establish adequate communication, preferably through his own skills or at least through an interpreter. He must understand, however, that the ability to use sign language does not alone guarantee communication, and that a grasp of the thought processes of low-verbal deaf persons, which is developed over a long term, is essential.

The counselor's own frustration due to his inability to communicate with a deaf client may produce adverse counseling attitudes that will elicit negative (and seemingly disturbed) reactions from the client.

Recognition of certain behavior aberrations which frequently accompany early profound deafness will prevent much misdiagnosis. For example, a deaf person's communication may depend to a high degree on motor activity, and this may appear to be a manifestation of anxiety and agitation. Cultural isolation may also result in the deaf person having a different value system from the norm. He may, for example, consider it appropriate to absent himself from work in order to attend social functions in the deaf community. Immediate gratification usually takes precedence over long-range planning with this type of client.

The counselor should not place complete reliance on reports of deviant behavior from other agencies or establishments. Many educational programs are rigid in their management of deaf children, and this could provoke temporary maladaptive behavior that might not reflect a client's true behavioral patterns. Psychological evaluations that show great variance should be checked against behavioral history and client reports. However, the client's initial narrative will not necessarily be fully reliable either, because communication difficulties may distort the information conveyed and because the client may be reluctant to relate unsuccessful past behavior.

Where emotional disturbance is a factor there is a need for long range and continuing evaluation of the deaf client. This should include observation in the home and community since deviant behavior will often be revealed only under stress situations. On the other hand, occasional brief displays of emotional upset do not warrant a diagnosis of chronic emotional disturbance. The majority of emotionally disturbed deaf clients cannot be considered mentally ill by any means. They are usually underexposed, underdeveloped persons who will make a reasonable adjustment with proper guidance and training.

Counselors experienced in working with deaf become alert for possible emotional disorders when:

School and other records so indicate. Reports from teachers, family members and others to whom the client relates may mention usual reactions. A medical record of premature birth or maternal rubella may suggest complications. If the client is referred by another agency, the case history and reason for referral may relate to emotional problems.

The client's verbal behavior betrays inconsistencies. When the client is self-referred, the reason he gives for contacting the counselor may indicate problems; where he has recently left or lost a job, his explanation may not jibe with known job conditions or may be definitely bizarre. His expressed self-concept and reactions to others may suggest inability to accept responsibility and a tendency to blame others for his failures; on the other hand, he may be depressed and

self-deprecatory. *The client is unable to cope with the usual stresses of deafness.*

A list of behavioral characteristics has been compiled as an aid in classifying deaf persons with emotional disorders. (9)

Referrals

The counselor may expect to receive referrals of emotionally disturbed deaf clients from the usual sources of schools, institutions, agencies, and families. In addition, he may identify as emotionally disturbed certain clients who are originally referred for different secondary disabilities. Emotional stress can, for example, trigger organic responses, as in epilsepsy.

In collecting data from the schools which will aid in identifying and evaluating problem clients, the counselor may find it useful to devise one or more check lists for distribution to school personnel who have worked directly with the client. These lists could include general personal adjustment skills and specific vocational performance skills, rated from poor to excellent.

A similar check system may be needed to obtain information from community resources about clients who have finished school or dropped out. In case-finding procedure for such clients it should be noted that the adult deaf person with an emotional problem usually does not function as a member of the deaf community. Hence, the counselor should ensure that availability of services is known to local and state police departments, hospitals, churches, welfare agencies, public health departments, children's services, schools, and physicians in the locality. He might also initiate a program of community information designed to reach individuals or families who would not otherwise be contacted.

EVALUATION

About two-thirds of all cases of emotional disturbance in deaf persons result from functional disorders growing out of environmental situations. These relatively mild, short-term cases will probably not need comprehensive evaluative services. They can be handled by the counselor himself, or by local diagnosticians. The more experienced the counselor is with deaf clients and the better his communication skills, the more he will be able to rely on his own observation in determining the severity of the problem. Where he makes use of local professionals for evaluation, he will need to caution the tester against the use of tests that do not apply to low-verbal deaf persons. The counselor's understanding

of the problems of deafness will help him to choose his professional services with care, since for deaf clients it is more important to use a good psychologist, preferably one trained and experienced in working with deaf people, than a widely standardized test. Careful choice will ensure that appropriate tests are administered in each case. It should be remembered, however, that evaluation should not depend on tests alone, but also on observation in life situations. A general discussion of testing deaf clients and a list of tests which have been found useful is given on page 12.

The remaining one-third of the cases of emotionally disturbed deaf clients are those who need psychotherapy to varying degrees. They are usually chronic cases; that is, persons with histories of emotional maladjustment. They, and any other client that the counselor suspects of deep-seated emotional disorder as suggested in the identification section, will probably need comprehensive evaluation at one of the existing rehabilitation centers. Chronic cases may, however, need initial referral for long-term therapy in a hospital setting. Conversely, crisis intervention requires immediate help from the counselor and may often be dealt with best if the client is not removed from his familiar environment. Referral to an out-of-town center at such a time might only add to the client's instability, since it would not only involve a waiting period while his problem remained unsolved but would require a readjustment on his return to the home setting.

The object of a comprehensive evaluation for the deaf client who is considered emotionally disturbed will be to obtain professional information and opinions as the the extent of his disabilities and to learn how he behaves under various conditions, so as to determine strengths on which to build, weaknesses for which to counsel, and situations to avoid in at least the initial community and vocational placement. Positive information that the counselor may wish to emphasize in requesting an evaluation includes: how well the client is able to relate to peers and authority figures; how much he can use residual hearing, if any; his oral skills; his intelligence level; and the possession of any outstanding talents, or strong interests and preferences. Negative information that will be essential for working with the disturbed client includes a knowledge of those situations that generate manifestations of disturbance; the client's obvious weaknesses and dislikes; and the kind of environmental stresses that would prevent steady employment. With this information it will be possible to determine the need for and extent of therapy, training, and other services.

For a description of evaluation techniques used in the New

York program for mental health the counselor can refer to the report mentioned on page 37 (No. 9 in the bibliography).

Even in chronic cases, emotional disturbance is not a static condition but rather a continuum ranging from the psychotic state, where institutional confinement and intensive therapy are required, to the point where the client is able to function effectively in the community with minimal follow-up services. The client's emotional health determines his status on this continuum and defines the services he will need at any one time. He may need help from mental health and other community agencies during the rehabilitation process and the counselor should establish and maintain cooperative working relationships with these agencies to avoid fragmentation of the casework.

The counselor may prefer to refer the deaf client with severe emotional problems to a mental health facility for treatment, but some counselors interrupt the rehabilitation process completely until the client is released. Where feasible, the counselor should continue to serve the client in the therapeutic setting through a cooperative working relationship with medical and psychological personnel. In order to facilitate recovery the client must have an opportunity to move back into the community in gradual stages. In addition to the therapeutic values, these ventures into the community give the counselor the opportunity to carry out continuous evaluation procedures. The following outline suggests the procedural steps and indicates the areas for which the counselor is mainly responsible.

Counselor

Identification
Diagnosis of client as not immediately trainable or employable

Therapeutic setting

Treatment by psychiatrist or psychologist
Cloistered training center and/or halfway house
Pre-vocational training and evaluation

Counselor

Re-identification and diagnosis

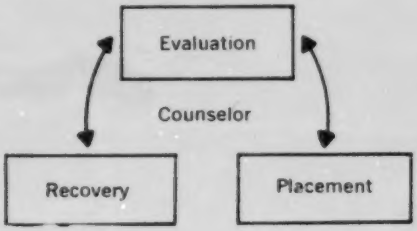
Community placement-counselor-with mental health services

Trial job placement with close follow-up
Retraining and/or job placement as indicated
Self maintenance
Self employment or good-on-the-job adjustment
Phasing out of counselor support

Embodied in this overall process is the concept of the counselor as a case manager functioning to satisfy client needs and acting as the liaison between the client and all agencies involved. The

emotionally disturbed deaf person needs the stability of continuing counseling help and the knowledge that someone who understands his unique problems is always available. The counselor also evaluates the productiveness of the services provided, and the client's adjustment at each stage, thus conducting a simultaneous and coordinated dual *evaluation* toward the mutual goals of emotional *recovery* and vocational *placement*.

The following diagram illustrates the above statement and demonstrates the counselor's involvement in a circular approach to the evaluation process.



Some of the procedures involved in both the recovery and placement aspects of the evaluation process are outlined below.

Evaluation for Recovery

With the most severe cases, evaluation will commence in the therapeutic setting, where there should be team discussions at all stages between the rehabilitation counselor, the professional personnel, representatives of service agencies as necessary, and at times the client.

In hospitals that do not already provide special services for deaf patients, the counselor might initiate volunteer visiting by persons skilled in communicating and encourage these volunteers to sponsor socials, parties, and outings. Visits by clergymen from churches for the deaf of various denominations should also be solicited. Manual communication classes for staff volunteers and interpreters could be established. Where possible, compatible deaf patients could be grouped in the same ward.

These procedures aid in bridging the gap between hospital and community and provide the counselor with evaluation sources in determining the progress of the client's recovery.

The marginal deaf client (in the case of emotional disturbance, one who has either recovered from or is not judge to have severe prolems) may be evaluated at a service center in cooperation with

mental health agencies or resource persons. The objectives of such an evaluation are described above (p. 38). Services would include supportive counseling, observation by professionals (preferably those experienced in working with deaf clients), education programs, work readiness programs, services to upgrade levels of independent functioning, and introduction or beginning readjustment to the deaf community.

Follow-up evaluations for all clients may occur in a variety of settings. They should include continued counseling by the same counselor, periodic psychiatric examinations, frequent family or home placement checks, and client integration into the deaf community and accommodation to the community at large.

Evaluation for Placement

Special procedures are needed in evaluating the employability of mental hospital patients. After the initial hospital adjustment, when the client is no longer in the dangerous stage, he should be provided with an occupational assignment and counseling on various occupational areas. Assuming satisfactory performance reports, arrangements might then be made for him to reside in a halfway house while continuing his daily hospital assignment. The next step would be part-time or sheltered employment in the community while still residing at a halfway house. Finally, full-time, paid employment and eventual home placement would be attempted. Evaluation of placement and recovery proceed in close conjunction at this stage.

Routine evaluation procedures that will need to be carefully monitored in the case of deaf persons with emotional problems are medical examinations (emphasizing possible organic complications); choice of appropriate psychological tests; tests of communication skills; and observations of adjustment capability, such as the level of emotional control. In evaluating educational achievement of deaf persons, a clear distinction should be made between the number of years of schooling and the actual functional grade level.

Vocational evaluations will include performance tests, such as the GATB (with the precautions mentioned earlier, p. 12), work sample tests such as the TOWER system (p. 29), workshop evalutions, counseling exploration of client interests, and evaluation in trial placements by employers, the counselor, and the client himself. The evaluation will continue, with upgrading as indicated, in such job settings as sheltered workshops, on-the-job training programs, and eventual competitive employment.

TRAINING

The security of familar surroundings plays a large part in the therapeutic process. If the emotionally disturbed client can remain close to home during the training period, so much the better. Where his environment has been a causal factor in his emotional disturbance—because of stress conditions in the home, rejection, or overprotection by the family, and so on—attempts should be made to correct these problems through family counseling and similar aid. Only if this is not feasible should placement in a residential rehabilitation center, halfway house or foster home be explored.

For obtaining training in the locality, the counselor might usefully develop a personal directory of local facilities and agencies, both those that already provide services for deaf persons, if any, and those which provide the kind of services that the emotionally disturbed deaf client may require. If certain facilities and agencies have not, in the past, provided services to deaf persons, the counselor may be able to initiate new programs. In many cases these agencies are willing to cooperate in such ventures if they are contacted and if they are given direction and support by the counselor. Examples of facilities that can be developed include Goodwill Industries and the Easter Seal programs.*

Because emotional problems can be present in deaf clients with high intelligence and educational aptitude the counselor † may need to investigate local community colleges for training opportunities when the client is sufficiently stabilized. If he finds the college fully prepared to meet its obligation of serving all members of the community regardless of disabilities he can arrange programs for qualified students, including the provision of interpreters as needed. Ideally, he could preface such programs by discussing with the teachers concerned how to strike a balance between going out of their way to help deaf students and giving no attention at all to the problem.

In counseling situations aimed at improving emotional attitudes of abler deaf clients, the counselor might usefully discuss the psychological impact of communication barriers between hearing and

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* Local technical and trade schools are sometimes willing to accept qualified persons, even with limited communication skills, for courses such as dental technology, cosmetology, drafting, auto body work, and other trades requiring manual dexterity. In Maryland, St. Louis, and elsewhere, business schools have cooperated in setting up courses in key punch and computer programming.

† Without such problems these individuals would probably attend Gallaudet College in Washington, D.C., or the newly-established National Technical Institute for the Deaf in Rochester, N.Y.

deaf persons. The client needs to be aware that apparent rejection by a hearing person may be the expression of the latter's frustration as a natural reaction to his own insecurity in the situation. It usually has little bearing on anything the deaf person has said or done, but is a product of the difficult circumstances. A deaf person who can be brought to a full understanding of this can help the hearing person overcome his initial shock and feeling of insecurity.

Specific Training Areas

As has already been noted, emotional problems in the deaf person often result from, or are compounded by, inadequate communication with persons important to him. A first step in the training process will be to upgrade whatever communication skills the client possesses, with the eventual goal of enabling him to communicate adequately with parents, siblings and non-deaf friends.

Disturbed behavior may frequently be brought on in the deaf adult by his lack of, or inability to understand, information that he considers essential for dealing with his environment.* In a number of communities adult education classes for the deaf are now conducted on topics that would contribute to the individual's improved functioning, and the client can be encouraged to enroll. Where such classes are not available the counselor or training agency will have greater responsibility for providing this basic information.

For multiply disabled deaf persons functioning at low levels, a vital tool in imparting basic living skills is the ADL (Adjustment to Daily Living) program. Although this is used by most of the centers serving deaf persons, its importance in the rehabilitation of this clientele is not yet widely recognized by state agencies. The program involves a step-by-step approach to the development of skills in: using public transportation; hygiene and personal appearance; budgeting; using public facilities such as restaurants, barber or beauty shops, banks, and so on; interpersonal relationships with peers, authority persons, and family members; and work discipline.

The counselor may wish to make up a check list of skills, on which he can mark those he wishes to be evaluated and taught to the individual client, as briefly outlined below:

Mechanical

Arts and crafts

* For example, he may be highly disturbed by payroll deductions, increased insurance premiums or tax demands, or by his inability to obtain a driver's license.

Use of hand tools
Power machine operation
Industrial driving
Fork lifts
Cranes . . . .
Occupational vocabulary . .

Clerical

Typing
Filing
Bookkeeping . . .

Custodial . . .

PLACEMENT

A key concept in the over-all rehabilitation process of the emotionally disturbed deaf person is that work serves as a form of therapy. It is regarded by psychiatrists as part of the total treatment. Appropriate and acceptable placement is thus essential, preferably in the home community and reasonably close to mental health services, which may be needed.

If evaluation and training procedures have been carefully followed, placement should be a routine process. Specific considerations may be summed up as follows:

> Where the client has been hospitalized, allow for his return to the community and to employment by gradual stages. (p. 40)
>
> Avoid employment situations in which the client has previously demonstrated disturbance reactions, and those with environmental stresses that would prevent steady employment. (p. 38)
>
> Try as far as possible to train and place the client in his home community. (Above) Encourage concentration on skills that can be used in local industry.

In addition, when approaching an unfamiliar employer the counselor should investigate whether or not he has previously hired deaf persons and will be familiar with the general adjustments that are necessary. If not, some orientation must be given and insight gained before the first encounter between deaf client and prospective employer, especially where emotional problems are present.

The counselor will need to determine how much information to release on the client's problems, and to whom. It will be necessary for client protection and job retention that certain persons in the administrative and supervisory heirarchy receive privileged information to enable them to deal effectively with the

client/employee. Without their awareness of the problem, interpersonal confidence in the job setting is restricted, and the client becomes overdependent on the counselor. The counselor is, however, justified in withholding information that will not be relevant, and in stressing abilities. The client who is capable of decision making should be given the option of signing a release slip for such information, so that he is aware of the communication channels open to him.

* * *

The topic of follow-up has been covered in the chapter on general principles and practices. The section concerned with follow-up may be found on pages 17–22.

CHAPTER 4

Learning Disabilities

INTRODUCTION

There are characterisitics of behavior that are common to both deaf and hearing people. These behaviors occur on a continuum and the counselor's concern rests with the severity of atypicality. Among the deaf population there are individuals who are atypical in their ability to learn. Some of those who have been called low verbal, or under-achieving, deaf individuals may have had a specific learning disability.

After a thorough evaluation and assessment it is sometimes found that these individuals are not mentally retarded, severely emotionally disturbed, culturally deprived, nor do they have sensory impairments other than deafness. They may have had the best of educational experiences in classes for the deaf, but still they do not learn. Despite the efforts of their teachers, it is sometimes difficult to discover why their achievement is at such a low level or why it fails to increase over a long period of time. It is even more difficult to find ways in which these individuals can be helped to learn.

Deaf persons present a severe language and communication problem. In some cases, the vocational rehabilitation counselor may have attributed failure to learn to the communication problem, without considering the possibility that other learning disabilities exist and may be contributing to the problem. If these learning disabilities can be identified through differential diagnosis and ameliorated through remediation, the deaf person may be able to function at a higher level. The remediation of a learning disability may be viewed as part of the rehabilitation process.

The vocational rehabilitation counselor may have the tendency to utilize the deaf person's assets. It might in some instances be more helpful to examine the deficits for the possibility that more normal adjustment can be reached by ameliorating the learning

disability through remedial training. The identification and diagnosis of specific learning disablities may provide additional information which will help the vocational rehabilitation team decide whether to focus on the deaf person's assets or his deficits.

THE PROCESS OF IDENTIFICATION

The condition of deafness may create atypical behavioral patterns. Cultural deprivation, poor instruction, emotional disturbance, learning disabiiities, and mental retardation also cause atypical behavior. The same behavioral symptoms may result from different causal factors. The question is: "How do we identify deaf individuals who have specific learning disabilities?" The first step in identifying the deaf person with an accompanying learning disability should be part of the same identification procedure for identifying all atypical deaf individuals among the normal deaf population.

In order to identify the atypical individual, it is necessary to develop a list of symptomatic behavioral correlates. The behavioral check list included here is an attempt to categorize the atypical behaviors. The check list has several uses: (1) It may be given to professional personnel as a part of the routine gathering of information; (2) it will help parents and school personnel to focus on specific behavior; (3) it can be used as a basis for referral.

The individual's personal case file is another source for identifying potential behavioral correlates to learning disabilities. The reports of parents, teachers, principals, and employers may provide information which is helpful in case finding. Many deaf individuals with an accompanying learning disability may be found in segregated special classes within day schools and in residential schools for the deaf.

The severely handicapped individual with a learning disability will present obvious learning problems to all who come into contact with him. The major problem is to educate the professions and the public to the behavioral symptoms so that the proper referral can be made. This means that the vocational rehabilitation counselor must develop and clearly delineate lines of referral.

The application of a behavioral check list may help vocational rehabilitation counselors to identify atypical deaf individuals. Those persons suspected of a specific learning disability should be referred for assessment, evaluation, and diagnosis. A thorough assessment by a qualified psychological examiner, medical doctor, ophthalmologist, and educator will exclude the majority of poten-

tial causal factors and help pinpoint the nature of the learning disorder. It should be noted that only a small percentage of those who are referred will be found to have a specific learning disability. There are no hard data, however, which establish prevalence.

There are, for example, some specific learning disability tests and observational approaches which the learning disability specialist utilizes to determine the existence of a visual perception problem. Some examples of tests of visual perception are listed in Appendix D. Such tests assist in the diagnosis of the following visual perception disabilities:

1. Loss of directional sense for lines in relation to each other. Individual has difficulty in considering relationships of his body to objects around him.
2. Inability to recognize simple objects, yet being able to read and recognize symbols.
3. Inability to recognize written symbols in isolation. Different parts of the brain are affected. The subject can write but cannot read what he writes.
4. Compensatory eye movements.
5. Difficulty in perceiving moving objects.
6. Fixation on one detail rather than moving or fluctuating.
7. Inability to scan or examine in search.
8. Lack of perceptual speed.
9. Poor eye-hand coordination.
10. Poor visual form perception.
11. Poor figure-ground perception.
12. Poor memory for sequencing visual stimuli.
13. Poor visual closure.
14. Poor visual discrimination.

A Check List for the Identification of the Atypical Deaf Adult

Estimate expectancy for learning

1. Mental age/chronological age ratio over an extended period.
2. Poor scores on intelligence tests suited to deaf persons.
3. Discrepancy between verbal and performance behaviors.

Assess level of achievement

1. Low grades.
2. Poor acquisition, retention, and use of symbols in reading, writing, arithmetic (receptive, expressive, and inner language).
3. Low achievement test scores.

Estimate discrepancy between expected and actual achievement

Medical correlates

1. General health.

2. Audiological performance.
3. Visual.
4. Neurological.
5. Implications for medication.

Examine psychological correlates

1. Visual-perceptual disorders.
   (a) Visual motor disorders.
   (b) Visual closure.
   (c) Visual figure-ground differentiation.
   (d) Spatial relations.
   (e) Perceptual and shape constancy.
2. Auditory-perceptual disorders (hard of hearing)
   (a) Auditory closure.
   (b) Auditory figure-ground differentiation.
   (c) Auditory discrimination.
3. Kinesthetic and haptic perceptual disorders (short-term or long-term)
   (a) Symbolic versus non-symbolic.
   (b) Sequential versus global.
   (c) Deliberate versus incidental.
   (d) Recall.
   (e) Recognition.
4. Memory disorders.
   (a) For visual stimuli.
   (b) For acoustic stimuli.
   (c) For recognition tasks.
   (d) For recall tasks.
5. Integrative disorders
   (a) Inter-sensory processing.
   (b) Intra-sensory processing.
6. Symbolic disorders
   (a) Spoken language.
   (b) Reading.
   (c) Writing.
   (d) Arithmetic and mathematics.

Other factors affecting learning

1. Attention.
   (a) Distractibility.
   (b) Lack of responsiveness to visual and tactile stimuli (also auditory stimuli for the hard of hearing).
2. Motivational disorders
   (a) Low need for achievement.
   (b) Low level of aspiration.
3. Perseverative behavior.
4. Poor self-concept
   (a) Personal care.
   (b) Underestimation overestimation of own capacities and abilities.
   (c) Physical abnormality.
   (d) Impact of segregation.
   (e) Actual or pseudo paranoid behavior.
   (f) Social disorientation.

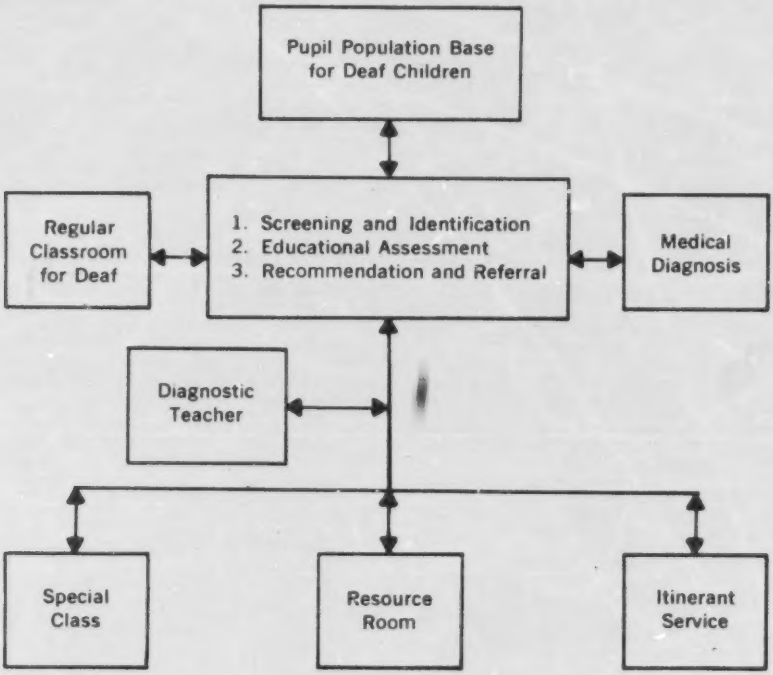
5. Inconsistent work study habits
6. Emotional lability
   (a) Lack of control of aggressive biological drives.
   (b) Inability to control responses.
      (1) Withdrawal
      (2) Aggressivenesss
      (3) Apathy
7. Failure syndrome
   (a) Expectation of failure.
   (b) Low goal orientation.
   (c) Disproportionate frustration and collapse occasioned by isolated failure.
8. Dependency syndrome
   (a) Immature behavior.
   (b) Inability to cope with new situations.
9. Lack of responsiveness to conditioning.

The characteristics exhibited by people with learning disabilities are diverse and present no consistent behavioral pattern. This complicates the development of a definition which is descriptive and identifies the learning disabled as a group. Identification and definition are further complicated in that many of the behavioral symptoms found among individuals with learning disabilities are also found among normal or bright individuals who experience no difficulty in learning. A person might possess a learning disability that does not clearly manifest itself until he attempts to read, write, or compute arithmetic problems.

A diagnostic program which identifies specific learning disabilities should provide information which can be used to plan effective remedial programs. There are a number of agencies or organizations with professional staff who are trained to provide a variety of diagnostic services such as hearing evaluation, tests for visual acuity, intelligence tests, achievement tests, and psychological evaluations for socially maladjusted and emotionally disturbed children. Although diagnostic services such as these can be used as a foundation, they are not sufficient to provide the degree of specificity required for a comprehensive diagnostic program. In order to provide remedial services as soon as possible, it is desirable to screen, identify, and diagnose services in the schools. For this reason it is necessary to consider the referral process for children as well as for adults.

Figure I is a flow chart which represents the ideal administrative procedure for the identification and referral of deaf children who have difficulty in learning. Professionals who participate in the formal screening program should include classroom teachers, school physicians and nurses, school social workers, guidance and counseling personnel, speech correctionists, and school psychologists. Formal screening programs should be designed so that the

Flow Chart for the Identification, Assessment, and Referral of Deaf Children Who Have Difficulty in School



multiply disabled deaf person is tested every two or three years. Teacher referrals supplement the more formalized screening program. Children who do not have obvious problems are returned to their regular classes. If a child with a problem is not identified by the screening program, his teacher will make the referral when the child experiences difficulty in the classroom.

Individuals who are identified by the screening program as having learning problems are referred for individual testing or examintion to provide more detailed information upon which an educational recommendation can be based. In some cases, it may be necessary to make a referral to the family physician, audiologist, otolaryngologist, pediatrician, or other medical specialist. A child might be placed in a regular classroom and receive an itinerant service such as individual counseling, speech correction, or remedial reading. He might also be put in a special education class.

These procedures for screening, individual evaluation, recom-

mendation, and placement meet the needs of the majority of children with educational problems, but they are neither sufficient nor adequate to diagnose specific learning disabilities or for making recommendation for specific remedial instruction.

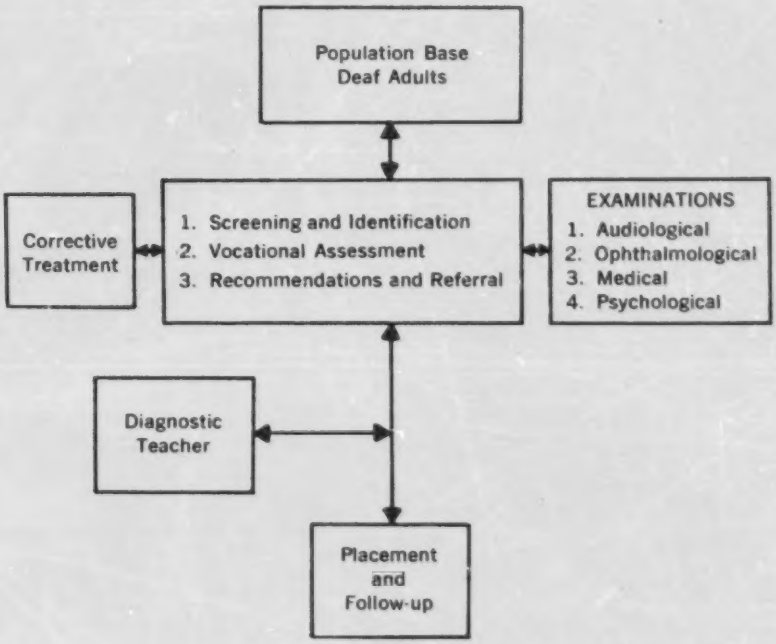


Figure II is a flow chart which represents the referral process for deaf adults. Many deaf individuals will be referred to the vocational rehabilitation counselor, who evaluates their vocational potential and places them in a work situation. If the deaf individual is in need of additional assessment or diagnosis, the counselor refers him to the appropriate diagnostic service. If no corrective treatment is indicated, the deaf person may be placed in a work situation. There may be occasions, however, when it is necessary to refer the individual for corrective treatment before a job placement can be made.

When the usual tests do not reveal the cause of the individual's failure to learn, it may be helpful to seek the services of a diagnostic teacher who can help provide both short-term as well as long-term assessment and remedial services, in the clinical setting as well as on the job.

Proper evaluation of the multiply disabled deaf person with

learning disabilities of necessity depends on a team of qualified personnel to perform the evaluation in a meaningful manner. For the adolescent or young adult deaf person these goals can be defined in terms of developmental learning, remedial instruction, or correctional instruction. Often these goals will be vocational in nature. The expertise of learning disability personnel covers areas such as academic, social, emotional, attitudinal, and motivational problems and motor skills, perceptual skills, and language.

In providing services in these areas, learning disability personnel apply a model based on between differences (or the differences between individuals) and on intra-individual differences (or the differences within one person). Evaluation is both formal and informal. Particularly the informal evaluation is performed over a continuous period of time. Referrals are frequently made to medical personnel with descriptive difficulties detailed. Learning disabilities personnel typically receive specific referrals dealing with the spectrum of discrepancies found in learning situations.

By the nature of the ramifications of prelingual, severe deafness accompanied by learning problems not typical to the normal classroom setting, the learning disabilities person must work as a member of a larger team. Basic to this team is the classroom teacher and the administrative educational staff. It is most likely here that the original diagnosis of "Johnny doesn't function according to my expectations" is made. Obviously, substantiation from the home may be a major influence as well.

The team should be expanded to cover all possible contingencies. Specifically included, in addition to learning disabilities personnel and school staff, should be medical personnel (doctor and nurse), the psychologist, the audiologist, the school counselor, the vocational rehabilitation counselor, and other specialists as needed.

In most instances, case recording types of information, including school records, will yield information that might have great relevance to the specific problem.

A danger always present in the case of the multiply disabled deaf person is that lack of personnel qualified not only in their own areas of competence but also in the communication aspects of dealing effectively with the multiply disabled deaf person. This difficulty is well documented yet remains the pervasive problem in providing effective differential diagnosis. Efforts should be maintained continuously to add this dimension of professional competence in dealing with the deaf person with learning disabilities.

As noted, capacity levels of deaf persons with learning disabilities are made in two broad general categories: inter-individual differences and intra-individual differences. Without question,

there exist great gaps in psychological instruments that are effective with severely and prelingually deaf persons. There is no apparent reason, however, to abandon completely those instruments that yield some success, while continuing efforts proceed for development of new instruments. A fuller discussion of the testing of deaf clients is covered on pages 11–13.

Comparison of capacity and achievement in an individual's total performance is a major key in the diagnostic process. Discrepancies here lead to remediation, correction, and redevelopment of the educational program for the individual.

The team approach best comes into play in a controlled environment, such as a rehabilitation facility, which allows for the important aspect of *observation* of the individual's performance, function, and behavior by a team of qualified persons. In such a facility emphasis on such things as actual task performance, role playing, and determination of minimum task performance is of major importance.

Lack of performance may be accounted for in part by (1) lack of basic or previous information, (2) lack of retrieval ability, and (3) lack of availability of performance task—also intermittent performance.

Situations that are the most effective for differential diagnosis are all situations in which the client has a contact with qualified personnel. As an example, the first interview with the vocational rehabilitation counselor is literally loaded with potential for discovering both assets and liabilities in the client's behavior. The most obvious manner of behavior is simply: Does the client speak for himself? Beware of those situations in which an intermediary speaks for the client. The interview should be client-centered not intermediary-centered. Beyond this, the client's behavior, general appearance, understanding of the agency's function, rationale for coming for the interview, communication skills (not oral-manual, but intelligibility regardless of method), skill in completing the necessary forms, and general knowledge of his community (e.g., does he know his own doctor); these things and many more will yield information relevant to differential diagnosis. It must be remembered, of course, that deaf persons may have been educated in a self-contained environment, must be told things (they do not overhear), and often are incurious about the verbal aspects of a situation.

Following the initial interview, the counselor has the responsibility of calling upon the previously mentioned team members to obtain a complete case record. This information will dictate the next step to be followed in the evaluation process. It is at this point that geography comes into play. Rural-located counselors

and clients may face the prospect of referral to major urban areas for further evaluation or of developing an assessment team locally that is competent for further evaluation. In the major urban areas, rehabilitation personnel, if they have not already developed adequate evaluation resources, will be faced with the prospect of developing such resources. This is a responsibility that must be faced if the deaf client with a learning disability is to complete the continuing process of diagnosis leading to remediation, correctional education, and redevelopmental education which will lead ultimately to a vocational goal and attainment.

The vocational rehabilitation counselor must pay particular attention to behaviors which may suggest some visual impairment, such as redness of eye, inflammation, tearing, excessive blinking, unusual head position, squinting. Since the visual channel is the primary means for learning by the hearing-impaired person, it is particularly important to take vision into account. Certain visual disorders (which can be diagnosed during ophthalmological evaluation) may block visual input. Typically the ophthalmologist will evaluate the following ocular motor disorders: visual acuity, refractive errors, muscle imbalance, color vision, depth perception, eyedness, glaucoma, and structural anomalies such as cataracts.

If the ophthalmological report indicates no major visual problems related to the development of the eye muscles and the ocular motor system and yet the case records clearly demonstrate that the client has been unsuccessful in learning through his visual channels, the learning disability specialist investigates the area of visual perception. Visual perception refers to the ability of the individual to interpret or decode stimuli which are transmitted through visual channels. Visual perception disorders may stem from a dysfunction in the visual areas of the brain.

The Role of the Diagnostic Teacher

If an educational recommendation is to be based on the results of diagnostic tests, the individual or individuals making the evaluation and educational recommendation must not only be trained in formal and informal diagnostic techniques, but must also possess knowledge and understanding of the different kinds of remedial techniques which have been developed to eliminate, ameliorate, or compensate for learning disabilities in children.

When formalized diagnostic tests fail to provide sufficient information about the area of difficulty, remediation becomes part of the diagnostic process. The necessary diagnostic information may be obtained by working with a child over a period of time

and observing his approaches, successes, and failures in different kinds of learning situations. This requires the diagnostician to become a teacher, or the teacher to become a diagnostician.

Diagnostic teaching is the process of determining the nature and severity of specific learning or behavior disorders and their amenability to remediation through exploratory teaching probes in the areas of asset or deficit.

The concept of diagnostic teaching is based on the assumption that effective teaching procedures contain many of the same procedural steps and sequences which are found effective in diagnostic procedures. Individuals are placed in one or more carefully controlled learning situations and taught over a period of time. The task of the diagnostic teacher is to study the approach to problems, use of learning strategies, application of cognitive abilities, and the success with which the person learns under different conditions and teaching systems.

This kind of teaching provides additional diagnostic information and helps bridge the gap between the diagnosis and the implication of remedial programs. Thus, diagnostic teaching serves as an extension of the diagnostic sequence.

Continual evaluation should take place during the remedial process. If, for example, a remedial approach is successful in ameliorating one aspect of a learning disability, the teacher must reassess readiness and ability to work on more complex tasks. Similarly, if the client fails to progress, the diagnostic teacher must continue to make evaluations and diagnostic judgments as to why the client is not progressing, whether the remedial techniques being used are appropriate, or if other remedial techniques should be implemented. The continuous evaluation and assessment of behavior during remediation requires a thorough understanding of both formal and informal techniques of differential diagnosis and remedial methods.

The ultimate goal of diagnosis is to provide the maximum amount of useful information with respect to cause, prognosis, and treatment of the disability. A thorough diagnosis will convey all of this information. In the referral and treatment of individuals it is helpful to be able to attain a meaningful label which conveys information about the nature and treatment of specific problems. Relevant classification of a problem should lead to a relevant treatment. Classification has usefulness only in relation to a specific purpose or objective. The diagnostic teacher's greatest contribution is in the area of remediation.

CHAPTER 5

Other Disabilities

The classification "other disabilities" may be taken to include all of those in Kirk's definitions of exceptional children except the mentally retarded, the emotionally disturbed, and those with learning disabilities, the latter three being covered elsewhere in this manual. The definitions below are quoted from Kirk:

> The Visually Handicapped: The following two major categories are used to classify children with marked visual defects:
>
> a. The Partially Sighted—(1) children having a visual acuity of 20/70 or less in the better eye after all necessary medical or surgical treatment has been given and compensating lenses have been provided when the need for them is indicated (such children must, however, have a residue of sight that makes it possible to use this as the chief avenue of approach to the brain), and (2) children with a visual deviation from the normal who, in the opinion of the eye specialist, can benefit from the special educational facilities provided for the partially seeing, and (3) those who have undergone eye operations and require readaptation of the eye and psychological adjustment to such conditions as enucleation (removal of an eye) and (4) those with muscle anomalies and other conditions which necessitate re-education of the abnormal eye.
>
> b. The Blind—Those whose vision is so defective that they cannot be educated through visual methods.
>
> The Cerebral Palsied: Cerebral palsy embraces the clinical picture created by injury to the brain, in which one of the components is motor disturbance. Thus, cerebral palsy may be described as a group of conditions, usually originating in childhood, characterized by paralysis, weakness, incoordination or any other aberration of motor function caused by pathology of the motor control center of the brain. In addition to such motor dysfunction, cerebral palsy may include learning difficulties, psychological problems, sensory defects, convulsive and behavioral disorders of organic origin.
>
> The Crippled Child: Those who have an orthopedic im-

pairment interfering with the normal functions of the bones, joints, or muscles to such an extent that special arrangements must be made by the school. Included in the category of the crippled are (1) children who are born with handicaps (congenital anomalies) such as dislocated hips or joints, clubfeet, spina bifida (a congenital anomaly affecting the spinal cord), and other conditions, and (2) children who acquire a crippling condition through accidents or through infection, such as poliomyelitis (infantile paralysis), tuberculosis of the bones or joints, and so forth.

Children with Special Health Problems: Those whose weakened physical condition renders them relatively inactive or requires special health precautions in school. Children who have cardia (heart) anomalies, tuberculosis, anemia, epilepsy, and other abnormal physiological conditions, and those who are undernourished have been termed "delicate children" or "children with low vitality. (5).

IDENTIFICATION

The identification and classification of visual impairment in deaf clients is a complex and generally little understood problem. Although some young deaf children with visual impairment may demonstrate their symptoms in an obvious manner, others display symptoms less commonly associated with visual impairment. For example, the far-sighted child, in his efforts to move back from visual stimuli, may seem hyperactive. Identification of visual problems in this population is further complicated by the need for highly specialized examinations to uncover certain conditions; e.g., *retinitis pigmentosa* may not show up under conditions of standard eye examinations given even in the mid-teen years, since the individual often retains good vision in the center of the eye.

Generally, detection and identification of secondary visual problems is assisted by full and accurate case histories which may reveal behavior that is diagnostic for blindness. Obviously, the earlier problems of this nature are detected and treated, the less chance exists for the development of secondary adjustment problems growing out of the condition. Because of the extremely destructive nature of any visual defect in conjunction with deafness, ophthalmological examination is mandatory for detection of the deaf person with visual impairments.

Ophthalmological examination often requires the presence of an interpreter to facilitate communication. Physicians are sometimes handicapped in obtaining sufficient information about the client due to communication difficulties. The physician who does not know his patient well enough may be inhibited in prescribing radical (and often necessary) corrective measures.

Whereas grand mal epilepsy is generally identified early, petit mal conditions often elude identification; in the latter, symptoms may be misinterpreted by those who know the individual best but discerned by others (e.g., employers) who may question certain types of observed behavior. Medically, the identification of convulsive disorders is the responsibility of the neurologist.

Counselors responsible for planning for the multiply handicapped person should obtain sufficient information to assist in determining the course of treatment and the prognosis for the secondary condition.

In general the counselor should know all available resources that may facilitate further diagnosis and/or treatment for his hearing impaired client. There are within the state rehabilitation agency, or its supervisory organization, specialists in many of these secondary disabilities who can provide the initial direction to the counselor's search for assistance.

Young people being prematurely dropped from schools because of multiple problems need to be identified. Likewise, adults voluntarily retreating from the deaf social scene may be so doing because of the late development of additional disabilities or the aggravation of existing secondary problems.

Counselors need to make strong efforts to reach out to this multiply disabled deaf population by circulating among deaf groups, by contacting civic organization, hospitals and institutions.

Counselors dealing with multiply disabled deaf clients, especially those with highly visible secondary disabilities, need to be aware of any personal aversion to such conditions that may emerge as resistance to dealing with the problems or as inability to see beyond the disability to the assets available in the individual. (The biased counselor might, if feasible and necessary, refer a client to another counselor, who is better adjusted to severely handicapping conditions.)

EVALUATION

Of importance in evaluation of deaf-blind clients are the resources available to the counselor. These resources are different in urban areas from those in rural areas, although there is considerable overlap. Applicable resources are similar to those listed on pages 8–11.

The focus with the deaf-crippled client should be on motor skills and how the client uses or does not use his abilities. Counselors should, on the other hand, be alert to whether and how much the client relies on his disability for secondary gains. The group-

ing, deaf-crippled, may be further refined by classifying the disabilities under (1) neuro-muscular disorders, which includes palsy, stroke, the plegias, Parkinson's disease, and multiple sclerosis; (2) muscular-skeletal disorders such as polio and muscular dystrophy, and (3) convulsive disorders.

An orthopedic medical examination should be conducted, along with specialists' examinations as indicated for cardiac, arthritic, and similar problems. The goal in such an evaluation should be obtaining clues to the removal or circumvention of the physical problem if that is possible. The counselor should expect from the orthopedic evaluation a thorough description of the disability or disabilities, a statement of prognosis, and recommendations for treatment by surgery, bracing, or similar prosthetics.

Psychological assessment in general has been treated in the chapter on the rehabilitation process, page 12. Special problems for other disabilities include selection of tests suited to the client's special needs. For example, some tests have been adapted for use by the blind. If the upper extremities of the client are affected, some standardized tests are not valid.

Finally, secondary physical disabilities complicate the clients' problems not only physically but also by the emotional problems they may engender, problems that may then have to be dealt with by the counselor concurrently with the physical problems.

VOCATIONAL EVALUATION

The use of consultants in obtaining and assessing specialized information is particularly important for accurate identification and screening of the multiply disabled deaf person. Modified communication procedures will be required for special disabilities such as visual impairment. The extent of physical endurance is an important consideration for screening of the client with neuro-muscular and muscular-skeletal problems.

The local counselor responsible for evaluation ideally will often require the resources of a rehabilitation center for evaluation of the multiply disabled deaf client. Physical restorative procedures and various types of physical remediation may either be undertaken by the counselor on the basis of early study or be reserved for later attention by a rehabilitation center. This decision will depend, in large measure, on the nature of the remediation required, the locality best equipped to deal with the problem, and future objectives for the client.

Client needs will provide the rationale for selection of a facility when multiple disabilities are involved. For example, he may

need multi-disciplinary team approach, treatment in a sheltered environment, a group living experience, or highly specialized training and/or corrective resources. Or again a client may be in need of removal from his present environment to an environment providing different peer, superior, or other influences.

Even more than the general counselor, the counselor who deals with multiply disabled clients must have a realistic but positive outlook for the client's training potential. He should consider remediation first and then circumvention of the disability. This is a key attitude for successful counseling.

He should attempt to develop a specific potential, if not an actual, employment position for the client prior to initiation of training. Some multiply disabled deaf persons quite successfully complete a vocational skill training course and then for various reasons cannot be employed in the vocation for which they have been trained. In other words, more attention should be given to training for specific job openings. In relation to this concept, the counselor needs to provide close support and coordination to the trainer, if it is an on-the-job training situation. Such support can facilitate future employment.

The counselor for multiply disabled deaf clients must exercise more than ordinary creativity and originality in developing job positions for which multiply disabled deaf persons can be trained. It is helpful to keep abreast of general occupational information and specific job opportunities for severely disabled people. Informational publications such as *Paraplegia News* and *Performance* are available as spurs and inspiration to creativity.

In considering training resources for the multiply disabled client the counselor must look for architectural barriers. Does the building have steps or elevators and ramps? Are corridors, water fountains, rest rooms, and training areas suitable for use by trainees who have prosthetic appliances? Do adjustment to daily living and recreation programs consider the needs of neuro-muscular and otherwise disabled trainees? Ancillary services for trainees with handicaps other than deafness should provide medically oriented supervision on a 24-hour basis, a medication dispensing service, and a resident physician or registered nurse.

Some general characteristics of specific client groups can be anticipated. The deaf-blind client tends to be badly spoiled, wanting to be catered to and accepting little if any responsibility. He may need mobility training. He needs to learn to participate with others in social settings; it may be helpful to teach him how to play cards or to bowl.

The cerebral-palsied deaf client may also tend to manipulate his environment, being spoiled and accepting little responsibility.

He may be a clown or he may be quite obnoxious; he may be infantile; he may successfully attempt to exploit people around him. His communication ability may be very limited; he quite possibly will have no speech, lipreading, or writing skills and his sign language may be atrocious. He may demonstrate personality rigidity; he may demand a great deal of attention; he may be unable to fit into his peer culture and may therefore attach himself to adult persons. Yet in spite of this constellation of negative factors, he may have vocational aptitudes which, if developed, will lead to productive employment. The client's rigidity was conditioned; hence reconditioning through structured behavior responses may be possible. Personnel must decide which behavior is to be encouraged and which discouraged. Note that cerebral palsy need not necessarily be of the extreme spasticity type; it can be only a mild incoordination.

PLACEMENT

Placement for multiply disabled persons should be recognized as part of an adjustment process in which the client is replaced, at higher levels if possible, when he indicates readiness. Ultimate goals should not be underestimated, but tragedy can result from an initial overplacement in which the client fails. For example, sheltered workshops can be utilized, when so indicated by evaluation and diagnosis, as an initial step in a continuum of placement services. Move the client into placement as quickly as possible after he has indicated his readiness for such a move.

In considering types of jobs for multiply disabled clients the counselor must innovate and create, keeping up to date with industrial changes and placement possibilities developed elsewhere. Examples of unusual possibilities for multiply disabled deaf persons: (1) a cerebral-palsied deaf person was set up in a pool hall business in a small town; (2) a deaf-blind person works with a blind person in a vending stand business; (3) mentally retarded hearing persons have been set up in the automated egg business, a probable opportunity for multiply disabled deaf clients. The counselor can initiate also; for example, job development on a statewide basis would be helpful.

Architectural barriers should be considered in the placement process. Can the client operate automatic elevator buttons, are rest rooms usable, is lighting adequate, and are work areas free of clutter and accessible to the client? Structural modifications for a client's needs can be financed with federal funds if the employer permits.

* * *

The topic of follow-up has been covered in the chapter on general principles and practices. The section concerned with follow-up may be found on pages 17–22.

RECOMMENDATIONS

(The major aim of the workshop on the multiply disabled deaf was to devise a manual for rehabilitation counselors serving this type of client. However, any gathering of professional persons will conern itself with the needs and advancement of its field of work. The following recommendations were devised from suggestions of the various groups in the workshop.)

* * *

The Federal Government in its expansion of services to preschool handicapped children will find services to families with deaf children especially fruitful.

* * *

Parents of deaf children often receive inadequate or unrealistic information and advice from general practitioners and even medical specialists. There is need for a common sense manual about the problems of deafness for use in medical schools and as a general reference book. The Social and Rehabilitation Service should commission the preparation of such a manual, perhaps by graduate students in vocational rehabilitation.

* * *

Visiting specialists should be available to serve in the homes of preschool deaf children as consultants and as communication experts. (The Mott Foundation in Detroit is currently carrying on preliminary research in this area.)

* * *

Schools responsible for the care of deaf children are urged to establish medical diagnostic standards and procedures to facilitate early detection of physical problems. It is suggested that all children with atypical health problems obtain a thorough physical examination at least every five years.

* * *

Training programs for teachers of the deaf should include material to broaden the trainees' understanding of deaf persons with secondary disabilities and thus provide new professional resources for dealing with these problems.

* * *

There is need for preventive mental health services for deaf people at all ages. One possible approach is by psychologists and

psychiatrists working with teachers as consultants on emotional and behavioral problems of students. Schools are urged to provide this sort of consulting service.

* * *

A severe shortage of psychologists who are adequately trained to evaluate deaf clients exists. At present there are only three institutions in the nation engaged in training psychological evaluators for work with deaf clients. The number of such institutions must be increased to meet the growing demands and numbers of multiply disabled deaf persons.

* * *

Because of verbal difficulties, the use of psychological tests with deaf persons is attended by problems of understanding of instructions and of rapport with the tester. There is need for scientific validation of all types of tests for use with deaf persons. A workshop of behavioral scientists could perhaps bring this problem into focus. Certainly some start on research to adapt tests and testing procedures for use with deaf persons is long overdue.

* * *

More special centers for evaluation and rehabilitation of multiply disabled deaf persons are badly needed. The depth and complexity of multiple disabilities require both the specialized skill and experience and the team approach possible in a rehabilitation facility.

* * *

Group counseling sessions such as sensitivity training provide a setting within which a deaf person can express feelings and frustrations and thus get them out in the open. Such programs should be made more generally available.

* * *

Rehabilitation offices, community, state, and regional, must improve staff development activities to increase counselors' ability to work with multiply disabled deaf clients.

* * *

In-service training should be provided to rehabilitation counselors regarding all types of school programs, other disabilities, the specialists in these various fields, and how they may be related to the rehabilitation process.

* * *

There should be more effective utilization of related resources on community, state, and regional levels to develop a stronger team approach to serving deaf people with secondary disabilities.

* * *

Deaf persons in the community served by a rehabilitation office can be utilized in ancillary and supportive roles. For example, they can teach the staff the art of manual communication, provide insight into problems associated with deafness, and interpret for low-verbal deaf persons.

* * *

There should be greater cooperative effort on the part of vocational rehabilitation agencies, state, and local schools, the Professional Rehabilitation Workers with the Adult Deaf, the Council of Organizations Serving the Deaf, the National Association of the Deaf, and other state and national organizations in approaching the problems of deaf persons with secondary disabilities in view of the increased number of these individuals expected in coming years.

* * *

It is recommended that the National Association of the Deaf identify and publicize its symbol through newspapers and other media as is done by national health organizations related to other disabilities in order to familiarize the public with their work.

* * *

One pattern for revealing unmet needs of deaf persons is the project currently proceeding in Oregon which calls for cooperation among state institutions in identifying deaf patients with other disabilities who are not being served. Adoption by other states is recommended.

* * *

It is recommended that ophthalmologists nationally be advised (by using the AMA directory) (a) of interpreters available, in their areas, for assistance in examining deaf patients and (b) of the need to be alert for secondary disabilities resulting from the recent rubella epidemics (1963–65).

APPENDIX A

Service Centers for Deaf People

Rehabilitation Centers that Serve Multiply Disabled Deaf People

Alabama Center for the Deaf
Alabama Institute for Deaf and Blind
P.O. Box 268
Talladega Alabama 35160

Hot Springs Rehabilitation Center
Hot Springs,
Arkansas 71901

Vocational Rehabilitation
Florida School for the Deaf
Box 36
St. Augustine, Florida 32084

St. Petersburg Rehabilitation Center
St. Petersburg,
Florida 33733

Evaluation Center for the Deaf
P.O. Box 295
Cave Springs, Georgia 30124

Decatur Job Training Center
Division of Vocational Rehabilitation
3132 North Water
Decatur, Illinois 62526

Speech and Hearing Center
Program for the Deaf and the Hard of Hearing
Northern Illinois University
De Kalb, Illinois 60115

Crossroads Rehabilitation Center, Inc.
3242 Sutherland Avenue
Indianapolis, Indiana 46205

Iowa Vocational Rehabilitation Center
1029 Des Moines Street
Des Moines, Iowa 50316

The Deaf and Hard of Hearing Counseling Service, Inc.
1648 East Central
Wichita, Kansas 67214

New England Rehabilitation-for-Work Center of Morgan Memorial, Inc.
927 Washington Street
Boston, Massachusetts 02111

Lapeer State Home and Training School
Program for the Deaf Retarded
Lapeer, Michigan 48446

Michigan Rehabilitation Institute
Program for Severely Disadvantaged Deaf Men
Pine Lake, Route 3
Plainwell, Michigan 49080

Rehabilitation Center and Workshop of Greater St. Paul, Inc.
319 Eagle Street
St. Paul, Minnesota 55102

Minneapolis Rehabilitation Center
1900 Chicago Avenue South
Minneapolis, Minnesota 55404

Mankato Rehabilitation Center
Holly Lane
Mankato, Minnesota 56001

Jewish Employment and Vocational Service
Rehabilitation Program for the Deaf and Hard of Hearing
1727 Locust Street
St. Louis, Missouri 63103

New York Society for the Deaf
Prevocational, Evaluation and Training Center
344 East 14th Street
New York, New York 10003

Sunnyview Hospital and Rehabilitation Center
1270 Belmont Avenue
Schenectady, New York 12308

Vocational Rehabilitation Center
906 Penn Avenue
Pittsburgh, Pennsylvania 15222

Woodrow Wilson Rehabilitation Center
Fishersville,
Virginia 22939

Wisconsin Rehabilitation Center for the Deaf
309 West Walworth Avenue
Delavan, Wisconsin 53115

Rehabilitation Center and Workshop
Institute, West Virginia 25112

Community Service Centers for Deaf People

The Deaf and the Hard of Hearing Counseling Service, Inc.
1648 East Central
Wichita, Kansas 67214

Greater Kansas City Community Service Agency for the Deaf
Kansas City General Hospital and Medical Center
24th and Cherry Streets
Kansas City, Missouri 64108

Counseling and Community Service Center for the Deaf
403 Swissvale Avenue
Pittsburgh, Pennsylvania 15221

Callier Hearing and Speech Center
2819 Maple Street
Dallas, Texas 75219

Seattle Hearing and Speech Center, Inc.
18th and East Madison Street
Seattle, Washington 98122

Mental Health Service Centers for Deaf People

Mental Health Services for the Deaf and the Hard of Hearing
The Langley Porter Neuropsychiatric Institute
2305 Van Ness Avenue
San Francisco, California 94102

New York State Psychiatric Institute
722 West 168th Street
New York, New York 10032

Michael Reese Hospital and Medical Center
Institute for Psychosomatic and Psychiatric Research and Training
2959 South Ellis Avenue
Chicago, Illinois 60616

APPENDIX B

Bibliographies on Deafness and Other Disabilities

NOTE—*These bibliographies do not pretend to be exhaustive. They are offered as a possible introduction to the fields for the counselor who feels the need of further information.*

Deafness

1. *American Annals of the Deaf*, 5034 Wisconsin Ave., N.W., Washington, D.C. 20016. (Official organ of the Conference of Executives of American Schools for the Deaf and American Instructors of the Deaf. Published quarterly. The January issue contains a directory of services to deaf people and statistics on education.)
2. Best, Harry. *Deafness and the Deaf in the United States.* New York: Macmillan, 1943.
3. Institute for Research on Exceptional Children, University of Illinois, *Research on Behavioral Aspects of Deafness; Procedures of a National Research Conference on Behavioral Aspects of Deafness, New Orleans, Louisiana, May, 1965.* Washington, D.C.: Vocational Rehabilitation Administration, U.S. Department of Health, Education, and Welfare, n.d.
4. *Journal of Rehabilitation of the Deaf.* Knoxville Tennessee: University of Tennessee. (Quarterly of the Professional Rehabilitation Workers with the Adult Deaf.)
5. Quigley, Stephen P., ed. *The Vocational Rehabilitation of Deaf People, A Report of a Workshop on Rehabilitation Casework Standards for the Deaf, St. Louis, Missouri, May 23–27, 1966.* Washington, D.C.: Vocational Rehabilitation Administration, U.S. Department of Health Education and Welfare, n.d.
6. Switzer, Mary E. and Williams, Boyce R. "Life Problems of Deaf People," *Archives of Environmental Health*, XV (August, 1967).

Deaf-Blind

1. American Association of Workers for Deaf-Blind Persons, Inc. *Contemporary Papers*, II (December 1967), 1511 K Street, Northwest, Washington, D.C. 20005.

2. Burns, Daniel J., and Stenquist, Gertrude W. "The Deaf-Blind in the United States; Their Care, Education, and Guidance," *Rehabilitation Literature* (November 1960) 334–344.
3. Myklebust, Helmer R. *The Deaf-Blind Child, Publication No. 15.* Perkins School for the Blind, 1956.
4. *Rehabilitation of Deaf-Blind Persons* (7 vols.). Brooklyn, New York 10001: Industrial Home for the Blind, 1958.
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Emotional Disturbances

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APPENDIX C

Psychological Tests

The following listing merely records various tests used in different areas of human assessment as a guide to the counselor. The list does not pretend to be all-inclusive, nor does it constitute a recommendation of any particular test for use with deaf clients. Anyone interested in evaluating psychological tests for use with deaf persons should refer to the short discussion on page 12 of this manual and to the reference cited there. Actually, the literature on testing of the deaf consists, in the main, of gropings for suitable tests and their adaptation for use with the general community. This listing includes the name of the test, the authors, and the publishers; the tests are grouped by types or subject matter and in alphabetical order.

Achievement

California Achievement Test; Ernest W. Tiegs, Willis W. Clark; California Test Bureau.

Denver Developmental Screening Test; William K. Frankenburg, Josiah Dodds; University of Colorado Medical Center.

First Grade Screening Test; John Pate, Warren Webb; American Guidance Service, Inc.

Iowa Test of Basic Skills; E. F. Lindquist, A. N. Hieronymus; Houghton Mifflin Co.

Metropolitan Achievement Test; Walter N. Durost, Harold H. Bixler, Gertrude H. Hildreth, Kenneth W. Lund, J. Wayne Wrightstone; Harcourt, Brace & World.

Metropolitan Readiness Test; Gertrude H. Hildreth, Nellie L. Griffiths; Harcourt, Brace & World.

The Scholastic Testing Service Educational Development Series; O. F. Anderhalter, R. H. Baurnfeind; Scholastic Testing Service.

School and College Ability Test; Ralph F. Berdie; Cooperative Test Division.

Stanford Achievement Tests; Truman Kelley, Richard Madden, Eric Gardner, Herbert Rudman; Harcourt, Brace & World.

Wide Range Achievement Test; J. F. Jastak, S. R. Jastak; Psychological Corporation.

Arithmetic

Arithmetic Achievement Tests; William E. Kline, Harry J. Baker; Bobbs-Merrill Co.

California Arithmetic Test; Ernest W. Tiegs, Willis W. Clark; California Test Bureau.

Diagnostic Arithmetic; G. T. Buswell, Lenore John; Bobbs-Merrill Co.

New York Test of Arithmetical Meanings; J. Wayne Wrighthouse, Morris Pincus, Ruth Lowe, World Book Co.

Stanford Diagnostic Arithmetic Test; Leslie S. Beatty, Richard Madden, Eric F. Gardner; Harcourt, Brace & World.

Time Apperception Test; John N. Buck; Western Psychological Service.

Auditory

ADC Audiometer Manual; Audio Development Co.

Boston University Speech Sound Discrimination Picture Test; Speech and Hearing Center; Boston University School of Education.

Roswell-Chall Auditory Blending Tests; Florence G. Roswell, Jeanne S. Chall; Essay Press.

State University of Iowa Standard Tests of Musical Talent; C. E. Seashore; C. H. Stoelting Co.

Wepman Auditory Discrimination Test; Joseph M. Wepman, University of Chicago.

Character and Personality

Blacky Pictures; Gerald S. Blum; Psychological Corporation.

Bristol Social Adjustment Guides; D. H. Stoot, Emily G. Sykes; Educational and Industrial Testing Service.

California Test of Personality; Louise P. Thorne, Willis W. Clark, Ernest W. Tiegs; California Test Bureau.

Children's Apperception Test (CAT); Leopold Bellak, Sonya Bellak; C.P.S., Inc.

Emergency Scales; Grace H. Kent; Psychological Corporation.

Eysenck Personality Inventory; H. J. Eysenck, Sybil Ensenck; Educational Industrial Testing Service.

Goldstein-Scheerer; Kurt Goldstein, Martin Scheerer; Psychological Corp.

Gordon Personal Profile; Leonard V. Gordon; World Book Co.

House, Tree, Person; Vytautas J. Bieliauskas; Western Psychological Services.

IPAT Humor Test; Donald L. Tollefson, Raymond B. Cattell; Institute for Personality and Ability Testing.

Kuder Preference Record; G. Frederick Kuder; Science Research Associates.

Michigan Picture Test; Samual Hartwell, Max L. Hutt, Gwen Andrew, Ralph Walton; Science Research Associates.

Mooney Problem Check List; Ross L. Mooney; Psychological Corporation.

Omnibus Personality Inventory Research; Center for the Study of Higher Education.

Psychodiagnostic; Hermann Rohrschach; Psychological Corporation.

Rogers's Test of Personality Adjustment; Carl Rogers; Association Press.

Shipley-Institute of Living Scale; Research Department of the Institute of Living.
Study of Values Personality Test; Gordon W. Allport, Philip Vernon, Gardner Lindsay; Houghton Mifflin Co.
Syracuse Scales of Social Relations; Eric F. Gardner, George G. Thompson; Harcourt, Brace & World.
Tests of Creative Thinking; Kaoru Yamamoto; Bureau of Educational Research.
Thematic Apperception Test; Henry A. Murray; Harvard University Press.
Vineland Social Maturity Scale; Edgar A. Doll; American Guidance Service.

Diagnostic Reading

Durrell Analysis of Reading Difficulty; Donald D. Durrrell; World Book Co.
Gates, McKillop Reading Diagnostic Tests; Arthur I. Gates, Anne S. McKillop; Teacher's College Press (Columbia University).
Gilmore Oral Reading Test; John V. Gilmore; Harcourt, Brace & World.
Gray Oral Reading Test; William S. Gray; Bobbs-Merrill Co.
Monroe Diagnostic Reading Test; Marion Monroe; C. H. Stoelting Co.
Monroe Group Reading Test; Marion Monroe; Houghton Mifflin Co.
Primary Reading Profiles; James B. Stroud, Albert Hieronymus, Paul McKee; Houghton Mifflin.
Rosewell-Chall Diagnostic Reading Test; Florence G. Roswell, James S. Chall; Essay Press.
Spache Diagnostic Reading Scales; George D. Spache; California Test Bureau.
Word Discrimination Test; Charles B. Huelsman, Jr.

Handwriting

Ayres Handwriting Scale; Leonard P. Ayres; Cooperative Test Division.
Thorndike Handwriting Scale; Edward L. Thorndike; Teacher's College Press.

Intelligence

A Point Scale of Performance Tests; Grace Arthur; C. H. Stoelting Co.
California Test of Mental Maturity; Elizabeth T. Sullivan, Willis W. Clark, Ernest W. Tiegs; California Test Bureau.
Cattell Intelligence Scale; Psyche Cattell; Psychological Corporation.
Columbia Mental Maturity Scale; Bessie Burgemeister, Lucille Blum, Irving Lorge; World Book Co.
Davis-Eells Games; Allison Davis, Kenneth Eells; World Book Co.
Detroit Tests of Learning Aptitude; Harry J. Baker, Bernice Leland; Public School Publishing Co.
Gessell Developmental Schedules; Arnold Gessell; Psychological Corp.
Goodenough-Harris Draw-a-Man-Test; Dale B. Harris, Florence L. Goodenough; Harcourt, Brace & World.
I. Q. Kalculator; Personnel Press, Inc.

Kit of Reference Tests for Cognitive Factors; John W. French, Ruth B. Ekstrom, Leighton A. Price; Educational Testing Service.

Leiter International Performance Scale; Russell Graydon Leiter; Santa Barbara State College Press.

Lorge-Thorndike Intelligence Tests; Irving Lorge, Robert L. Thorndike; Houghton Mifflin.

Mental Examiner's Handbook; F. L. Wells, Jurgen Ruesch; Psychological Corp.

Minnesota Percepto-Diagnostic; G. B. Fuller, J. T. Laira; Journal of Clinical Psychology.

Minnesota Pre-School Scale; Florence L. Goodenough, Katherine M. Maurer, M. J. Van Wagemen; Education Test Bureau.

Ontario School Ability Examination; Harry Amoss; Ryerson Press.

Otis Quick-Scoring Mental Ability Test; Arthur S. Otis; Harcourt, Brace & World.

Peabody Picture Vocabulary Test; Lloyd M. Dunn; American Guidance Service.

Pintner-Cunningham Primary Mental Test; Rudolph Pintner, Bess B. Cunningham; World Book Co.

Pintner Intermediate Test; Rudolph Pintner; World Book Co.

Pintner-Durost Elementary Test; Rudolph Pintner, Walter Durost; World Book Co.

Primary Mental Abilities; Thelma Gwinn Thurstone; Science Research Associates.

Raven's Progressive Matrices; J. C. Raven; Psychological Corporation.

Quick Screening Scale of Mental Development; Katharine M. Banham; Psychometric Affiliates.

Wechsler Maze Test; David Wechsler; Psychological Corporation.

Sangren Information Tests for Young Children; Paul V. Sangren; World Book Co.

Stanford-Binet; Lewis M. Terman, Maud A. Merrill; Houghton Mifflin.

WAIS; David Wechsler; Psychological Corporation.

Wechsler-Bellevue Intelligence Scale; David Wechsler; Psychological Corporation.

Wechsler Maze Test; David Wechsler; Psychological Corporation.

WISC; David Wechsler; Psychological Corporation.

WPPSI; David Wechsler; Psychological Corporation.

WPPSI Geometric Design; David Wechsler; Psychological Corporation.

WPPSI Mazes; David Wechsler; Psychological Corporation.

Language

Basic Concept Inventory; Siegfried Englemann; Follett Publishing Co.

Examining for Aphasia; Jon Eisenson; Psychological Corporation.

Halstead-Wepman Screening Test for Aphasia; Ward C. Halstead, Joseph Wepman; University of Chicago Clinics.

Illinois Test of Psycholinguistic Abilities; Samuel A. Kirk, James McCarthy; University of Illinois Press.

Parson's Language Sample; Joseph E. Spradlin; Journal of Speech and Hearing Disorders.

Slingerland Screening Test for Identifying Children with Specific Language Disability; Beth H. Slingerland; Educator's Publishing Service.

Reading Achievement

Botel Reading Inventory; Morton Botel; Follett Publishing Co.

Developmental Reading Test; Guy L. Bon, Theodore Clymer, Cyril Hoyt; Lyons & Carnahan.

Diagnostic Reading Test; Frances O. Triggs, Rachel Bear, George Spache, Agatha Townsend, Arthur Traxler, Frederick Westover; Committee on the Diagnostic Reading Test, Inc.

Durrell-Sullivan Reading Achievement; Donald D. Durrell, Helen B. Sullivan; Harcourt, Brace & World.

Gates Primary Reading Tests; Arthur I. Gates; Teacher's College Press (Columbia University).

Gates-MacGinitie Reading Tests; Arthur I. Gates, Walter H. MacGinitie; Teacher's College Press (Columbia University).

Monroe's Standardized Silent Reading Test; Walter S. Monroe; Bobbs-Merrill.

Science Research Associates Reading Record; Guy T. Buswell; Science Research Associates.

Reading Readiness

Gates Reading Readiness Test; Arthur I. Gates: Teacher's College Press (Columbia University).

Harrison-Stroud Reading Readiness Profiles; M. Lucile Harrison, James B. Stroud; Houghton Mifflin.

Lee Clark Reading Tests; J. Murray Lee, Willis W. Clark; California Test Bureau.

Monroe Reading Aptitude Test; Marion Monroe; Houghton Mifflin.

Murphy-Durrell Reading Readiness Analysis; Helen A. Murphy, Donald D. Durrell; Harcourt Brace & World.

Spelling

Ayer's Spelling Scale; Fred C. Ayer; Steck Co.

Webster Diagnostic Spelling Test; William Kottmeyer, Audrey Claus; Webster Division, McGraw-Hill.

Word Clue Tests; Stanford E. Taylor, Helen Frackenpohl, Nancy Joline; Educational Developmental Laboratories.

Visual-Motor

A.B.C. Vision Test; Walter R. Miles; Psychological Corporation.

Art Judgment Test; Norman C. Meier, Carl Seashore; Bureau of Educational Research and Service.

Ayers Space Test; A. Jean Ayers; Western Psychological Services.

Beery-Buktenica Developmental Test of Visual Motor Integration; Keith E. Beery, Norman Buktenica; Follett Publishing Co.

Bender Gestalt Motor Test; Elizabeth M. Koppitz; Grune & Stratton, Inc.

Benton Left-Right Discrimination and Finger Localization Test; Arthur L. Benton; Hoeber-Harper, Inc.

Benton Visual Retention Test; Arthur L. Benton; Psychological Corporation.

Marianne Frostig Developmental Test of Visual Perception; Marianne Frostig, Phyllis Maslow; Consulting Psychologists Press.

Harris Test for Lateral Dominance; Albert J. Harris; Psychological Corporation.

Lincoln-Oseretzky Test of Motor Impairment; William Sloan; C. H. Stoelting Co.

Macquarrie Test for Mechanical Ability; T. W. Macquarrie; California Test Bureau.

Memory for Designs Test; Frances Graham, Barbara Kendall; Montana State University.

Money Standardized Road Map Test; John Money, Duane Alexander, H. T. Walker, Jr.; Johns Hopkins Press.

Moore Eye-Hand Coordination Test; Joseph E. Moore; California Test Bureau.

Purdue Perceptual Motor Survey; Eugene G. Roach, Newell C. Kephart; Charles E. Merrill Books, Inc.

Stenquist Mechanical Aptitude Test; J. L. Stenquist; World Book Co.

Vocabulary

A Spoken Word Count; Lyle V. Jones, Joeph M. Wepman; Language Research Associates.

Core Vocabulary; Stanford E. Taylor, Helen Frackenpohl; Educational Development Laboratories.

Dolch Sight-Word Vocabulary; Edward W. Dolch; Garrard Press.

Phoneme-Grapheme Correspondence as Cues to Spelling Improvement; Richard E. Hodges, Edwin H. Rudorf, Paul R. Hanna, Jean S. Hanna; U.S. Department of Health, Education, and Welfare.

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